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Central University of Venezuela Faculty of Legal and Political Sciences Center for Postgraduate Studies Doctorate in Sciences, major in Law

Medical malpractice: Ethical, legal, and social aspects.

Doctoral Thesis presented for the title of Doctor of Science, majoring in Law

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Caracas, May 2023

Central University of Venezuela
Faculty of Law and Political Sciences
Center for Postgraduate Studies
Mention PhD in Law

Medical malpractice.Ethical aspects, social and legal.

Doctoral Thesis submitted to qualify for the Degree of Doctor of Sciences, specialty law

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SUMMARY

This research aimed to evaluate a sample of cases of medical errors in university health institutions in the metropolitan area of Caracas and their subsequent judicialization between the years 2015-2018, through criminal and civil complaints, to determine the causes that favor the emergence and frequency of medical malpractice, that is: (i) impunity and consequent social skepticism of punishment and anomie for safety in the absence of accountability; (ii) dehumanization and commercialization of the medical act (iii) union solidarity and absence of ethical sanctions by medical colleges (iv) deficiencies or deviations in university teaching of bioethics; (v) failures in health services and in State supervision and surveillance. We pose the following as the main question of this paper: Is medical malpractice a purely legal problem, or can it involve other factors related to professional ethics, both in its formative stages and in individual and professional practice, skepticism regarding the lack of social effectiveness of sanctions, or factors linked to the State's functions of provision, control, and supervision? The methodology employed was qualitative, documentary, bibliographic, analytical, evaluative, and field-based. An analytical and deductive reading of the problem posed was performed, as well as a critical analysis of the data obtained. The conclusions presented can be summarized as follows: There is a weakness in the bioethical and humanistic training of physicians, linked to the hidden curriculum. The existence of a crisis of values condemns compliance with deontological codes. Automatic solidarity in the medical profession could improve the quality of patient care, but it often generates cover-ups. Curricula should be reviewed and include medical malpractice, urging training and research in bioethics. It is important to reactivate Bioethics Committees in public and private healthcare institutions and to increase union participation in the control and prevention of medical malpractice. It was noted that it is impossible to carry out good medical practice in the absence of basic supplies. We emphasize the existence of impunity for medical malpractice crimes, not due to a lack of classification but due to a lack of investigation, failure to act or deficiently, incapacity, or lack of will to bring justice for acts or omissions. Finally, it is imperative to address existing weaknesses to provide fair solutions.

Descriptors: Malpractice, bioethics, dehumanization, solidarity, humanism, impunity.

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Date: February, 2019

ABSTRACT

The objective of this research was to evaluate a sample of cases of medical errors in university health institutions in the metropolitan area of Caracas and their consequent prosecution between the years 2015-2018, through criminal and civil complaints, to determine the causes that favor the appearance and frequency of medical malpractice, that is: (i) impunity and consequent social skepticism of punishment and anomie for security in the absence of imputability; (ii) the dehumanization and commodification of the medical act (iii) union solidarity and absence of ethical sanctions by medical colleges (iv) shortcomings or deviations in bioethics university teaching; (v) failures in health services and in the supervision and surveillance of the State. We pose the following as the main question of the work: Is medical malpractice a limited legal problem or can it involve other factors related to professional ethics, both in its formative stage and in its individual and union practice, to skepticism due to the lack of social effectiveness of the sanctions or to factors related to the functions of provision, control and supervision of the State? The methodology used was qualitative, documentary, bibliographical, analytical, evaluative and field. An analytical, deductive reading of the problem was made, as well as a critical analysis of the data obtained. The conclusions presented can be synthesized as follows: There is a weakness in the bioethical and humanistic training of the doctor, linked to the hidden curriculum. The existence of a crisis of values condemns compliance with deontological codes. Automatic solidarity in the medical union could improve the quality of patient care but tends to lead to cover-ups. Study plans should be reviewed and include medical malpractice, encouraging training and research in bioethics. It is important to reactivate the Bioethics Committee in public and private health institutions and greater union participation in the control and prevention of medical malpractice. It was warned that it is impossible to carry out good medical praxis in the absence of basic supplies. We highlight the existence of impunity in the crimes of medical malpractice not due to the absence of classification but due to the lack of investigation, failure to act or deficient performance, incapacity, lack of will to do justice by action or omission. Finally, it is imperative to improve existing weaknesses to provide fair solutions.

Descriptors: Malpractice, bioethics, dehumanization, solidarity, humanism, impunity.

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To God, almighty.

To the Central University of Venezuela, a World Heritage Site, whose open classrooms have welcomed me throughout my entire education.

To the Faculty of Law and Political Sciences and all its faculty members, who contributed to my training. Special thanks to Dr. Eduardo Meier G., who reviewed and corrected this research.

To all, thank you very much.

DEDICATION

To the victims of medical malpractice and their families, in honor of their memory. To practicing lawyers and physicians, with the hope that by deepening knowledge in this area, we can prevent harm and improve practices in the administration of justice, while serving as a non-aggression pact to reduce the intensity of the fratricidal battles between the two professions.

TUTOR APPROVAL

Caracas, February 28, 2019

Citizen
Professor Dr. Carlos Simón Bello Rengifo
Director of the Doctorate in Sciences, Mention in Law Present.-

I respectfully address you to inform you that attorney Jeannegda Catherine Valverde Farías, ID No. V-11,228,799, has completed her doctoral thesis: "MEDICAL MALPRACTICE. ETHICAL, LEGAL, SOCIAL ASPECTS," submitted to obtain the title of Doctor of Science, majoring in Law.

In this regard, I request that the Postgraduate Studies Committee propose to the Faculty Council the appointment of the jury for the respective defense. Without further ado, I bid you farewell.

Sincerely,

Dr. Raúl Arrieta Cuevas†

INDEX

SUMMARY 3
ABSTRACT 4
ACKNOWLEDGMENTS 5
DEDICATION 6
TUTOR'S APPROVAL LETTER 7
INDEX 8
INTRODUCTION 13
PROBLEM STATEMENT 16
IDENTIFICATION OF THE OBJECT OF STUDY 18
LOCATION 18
PURPOSE 18
HYPOTHESIS FORMULATION 20
GENERAL, FUNDAMENTAL, OR RESEARCH HYPOTHESIS 20
OPERATIONAL OR WORKING HYPOTHESES 20
GENERAL AND SPECIFIC OBJECTIVES 21
INCLUSION CRITERIA 22
EXCLUSION CRITERIA 22
METHODOLOGY 22

CHAPTER I. ETHICAL FACTORS GENERATE MEDICAL MALPRACTICE

1.1.-Conceptual framework 27
1.1.1.- Medical malpractice 27
1.1.2.- Bioethics 27
1.1.2.1.- Bioethics and Law 30
1.1.2.2.- General ethical and bioethical principles… 31
1.1.2.3.- The ethical principles derived… 32
1.1.2.3.1.- The right to the inviolability of human life 32
1.1.2.3.2.- Right to physical integrity and health 33
1.1.2.3.3.- Crisis in the application of the principles of bioethics 34
1.1.2.3.4.- The twilight of human life 34
1.1.3.- Medical error 35
1.1.4.- Anomia 36
1.1.5.- Union solidarity 36
1.1.6.- Impunity 37
1.1.7.- Impunity and social ineffectiveness of the norm 37
1.1.8.- Media trials… 40
1.1.9.- Media persecution 45
1.1.10.- Service failure 47

1.1.11.- Jurisprudence 49
1.2.-Medical ethics and deontology..... 58
1.2.1.- Historical background…..... 67
1.2.2.- Bioethical principles and informed voluntary consent 71
1.2.3.- Medical ethics and social conditions.....78
1.2.4.- Importance of the study of ethics in medicine..... 82
1.2.5.- Teaching models in medical bioethics..... 83
1.2.6.- Public ethics and private ethics in medical malpractice..... 86
1.2.7.- Ethical decisions in medical practice 87
1.2.8.- Organizational ethics of healthcare institutions… 100
1.3.- Artificial intelligence in the doctor-patient relationship..... 102

CHAPTER II. MEDICAL MALPRACTICE AND LEX ARTIS. MEDICAL ACT. IATROGENIA

2.1.-Medical malpractice..... 110
2.2.-Lex artis in medical practice…… 111
2.2.1.-Medical practice and the Law on the Practice of Medicine.....118
2.2.2.-Medical dyspraxis..... 119
2.3.-Iatrogenesis… 119
2.3.1.- Classification of iatrogenesis..... 120
2.4.-The medical act. Risks and possibilities of errors 121

CHAPTER III. DEHUMANIZATION AND EDUCATIONAL FACTORS AS GENERATORS OF MEDICAL MALPRACTICE.

3.1.-Medical narcissism..... 125
3.2.-The dehumanization of medical practice..... 130
3.3.-Relationship between Burnout and dehumanization of medical practice 134
3.4.-Ethical teaching in medicine and the hidden curriculum.....137
3.5.-Error as a disturbing agent of the medical act 138
3.6.-The negativity of accepting therapeutic maneuvers…..... 140
3.7.-The aggressive patient.....141
3.8.-Obstetric violence..... 145

CHAPTER IV. MEDICAL LIABILITY

4.1.-The medical assistance contract.....149
4.2.-Professional medical liability.....149
4.3.-Causal relationship between medical malpractice and medical liability..... 150
4.4.-The assessment of guilt in medical malpractice..... 155
4.5.-The civil and criminal liability of doctors..... 157
4.6.-Contractual and extracontractual medical liability 160

CHAPTER V. FACTORS INSTITUTIONAL SANITARYGENERATORS OF MEDICAL MALPRACTICE

5.1.-Responsibility of health care establishments 164
5.1.1.-Healthcare liability: Lex artis and lex praxis… 167
5.1.2.-Responsibility of students, medical interns and residents in health establishments 168
5.1.3.-Liability for lack, risk or inactivity 170
5.1.4.-Theories on the civil liability of public health establishments… 171
5.1.5.-The evaluation of the fact: The health action or omission 176
5.1.6.-Direct and indirect liability of the establishment health 177

CHAPTER VI. JUDICIAL FACTORS AND EVIDENTIAL LIMITATIONS IN MEDICAL MALPRACTICE

6.1.- Evidentiary limitations in medical malpractice 182
6.1.1.-Fraternity and solidarity among medical professionals 185
6.1.2.-Beneficial or harmful solidarity doctors' union… 186
6.1.3.-Solidarity and complicity 188
6.1.4.-The conspiracy of medical silence 188
6.1.5.-Medical history as evidence 190
6.1.6.-The autopsy… 192
6.1.7.-Impunity and medical malpractice 194
6.2.- The temporal and spatial scope of malpractice jurisprudence. 196
6.3.- Transitional justice and medical malpractice 198
6.4.-Mediation, arbitration and reparation agreements in medical malpractice 200
6.5.-Exemptions from medical liability 204
6.6.- Usefulness or uselessness of a law against medical malpractice ... 206

CHAPTER VII. LAW, MEDICINE AND SOCIETY
7.1.-Defensive medicine 212
7.2.-Moral damage due to medical malpractice 214
7.3.-Medical defamation. Yellow journalism 217
7.4.-Medical crisis and malpractice 219
7.5.-Scientificity versus effectiveness in medical practice 220
7.6.-Health, malpractice and medical interventionism 224
7.7.-Right to health as a human right 225

CHAPTER VIII. MEDICAL ERROR AND LAW.

8.1.-Differences between medical error and medical malpractice.....231
8.1.1.-Medical errors. Classification..... 231
8.1.2.-Ethical conduct when making a mistake 232
8.1.3.-Susceptibility to medical errors in Intensive Care Units (ICU)..235
8.1.4.-Mistakes in critically ill adults.....236
8.1.5.-Neurological emergencies and error vulnerability 237
8.1.6.-Errors in anesthesia, vulnerability and latent conditions 242
8.1.7.-Medical errors in surgery. Aesthetic tourism. Liposculpture..... 244
8.1.8.-Errors in transfusion medicine 248
8.1.9.-The discussion of medical errors.....251
8.1.10.-Error compensation 253

CHAPTER IX. PREVENTIVE ASPECTS OF MEDICAL MALPRACTICE

9.1.-Medical history as a preventive tool 258
9.2.-Prevention in the various medical specialties.....259
9.2.1.-Surgery.....259
9.2.2.-Unnecessary surgeries 259
9.2.3.-Infectology.....259
9.2.4.-Anesthesia 260
9.2.5.-Transfusion medicine 262
9.3.-Prophylaxis of errors and medical malpractice.....262
9.4.-The patient as an active agent in the prevention of medical malpractice..... 265
9.5.-The socialization of medicine in the prevention of medical malpractice 267
9.6.-Media persecution in the prevention of medical malpractice…269 9.7.-Bioethics in the prevention of medical malpractice.....271
9.7.1.- Legalization of bioethics as a preventive tool for malpractice… 272
9.7.2.- The insufficiency of bioethics to resolve conflicts…276 9.7.3.-The principles of biolaw..... 276

CHAPTER X. CASES SENTENCED FOR MEDICAL MALPRACTICE

10.1.-National cases sentenced for medical malpractice.....278
10.2.- Foreign judgment for medical malpractice. IACHR..... 307

CHAPTER XI. RESULTS. PAINTINGS. INTERVIEWS. CONCLUSIONS

11.1.-Analysis of results..... 320
11.2.-Tables 325

11.3.- Interviews… 333
CONCLUSIONS 337
RECOMMENDATIONS..... 342
BIBLIOGRAPHICAL REFERENCES 346
ANNEXES 366

Introduction

In the practice of medicine, as with any relational activity, conflictual situations arise, which are amplified by the legal rights at stake: health and life. Physicians must make decisions that could compromise the life of the patient, and the very dynamics and necessity of the medical act relieve the physician from questioning the possible negative consequences of their intervention. This attitude is closely linked to ethics and professional responsibility. Physicians find themselves in the position, derived from the human right to health and the ethical and legal obligations inherent to health services, of intervening per se. The very nature of these obligations gives rise to a double aspect: on the one hand, fulfilling them has consequences, and on the other, failing to fulfill them has sanctions.

At these times, the line between life and death for a patient becomes very blurred. The most appropriate course of action to adopt is uncertain, but the principles of respect for life, human integrity, the preservation of morality and health, patient rights, and compliance with the legal system and ethical and legal provisions always prevail. If the chosen course of action is not correct, it can result in an error or medical malpractice, the consequences of which will affect the patient, their family, the attending physician, and those close to them.

The philanthropic image of medical professionals has deteriorated over the last fifty years. The physician has been distancing himself from the Hippocratic model, to be considered a simple technician, or provider of another service, eager for economic and professional recognition, closely attached to a scientific model, distant in some cases from the human sensitivity inherent in the practice of classical medicine, whose humanism was upheld for medical posterity by the most qualified cultivators of ecumenical thought, such as Hippocrates, Aristotle and

Plato, who contributed essential concepts to define the spirituality of the act itself.

Currently, the practice of medicine is suffering from a process of dehumanization and technicalization, compounded by the latest advances and incorporations of artificial intelligence and telemedicine. This has led to social and moral transformations, especially in highly developed societies, with materialistic, hedonistic, value-deprived, frivolous lifestyles and a cult of banality. In this context, health has been transformed into an expensive product of a perverse market, which has made lucrative greed its leitmotif. This phenomenon is observed in developing countries, which, faced with conflicts and inequalities, are abandoning preventive and health-promoting health policies. This, coupled with the precariousness of justice systems and the costly access to private health systems, makes it more difficult to practice the Hippocratic model.

On the other hand, some doctors have uncritically identified with cutting-edge technology, abandoning its essence to the detriment of their professional identity. They project an image focused on higher socioeconomic status and personal gain, lacking sensitivity toward the most disadvantaged classes.

Anomie is a sociological concept referring to the lack of norms and rules that guide the behavior of individuals in a society, leading to a chaotic and disorganized existence; a phenomenon that has serious consequences for the social effectiveness of the norm and, therefore, for the protection of protected legal assets such as health, personal integrity, and people's lives. The effectiveness of a norm or a system of norms depends on the obedience it receives from its recipients. The situation in which there is widespread disregard for the observance of a set of norms describes a process of degradation or suppression of the effectiveness.

social norm, which could be a key factor allowing doctors to act irresponsibly and even negligently, generating a sense of impunity among health professionals, who do not feel obligated to follow accepted medical practices. Sometimes, the consequences of medical malpractice are not duly sanctioned by the competent authorities, which further accentuates the perception of impunity among doctors. This means that, instead of being an element that guarantees the social effectiveness of the norm, the law becomes an instrument that fails to channel the conduct of doctors toward ethical and responsible behavior.

In addition to the above, there is impunity for medical malpractice crimes due to “media justice,” which involves persecution in the media and on social networks, subjecting doctors to public ridicule but not bringing them to justice or providing effective judicial protection, to the detriment of the presumption of innocence and the right to defense. This coexists with weak, slow, and inefficient judicial systems, reminiscent of Cesare Beccaria’s maxim: “The certainty of a punishment, even a moderate one, will always make a greater impression than the fear of a more terrible one coupled with the hope of impunity.” (Beccaria, 2000)

In this sense, culture and tradition play a fundamental role in the anomie and consequent impunity that occurs in medical malpractice. The widespread belief that "the doctor is always right," the various superstitions related to health, and the lack of education about patients' rights are just some of the factors that contribute to the lack of clear norms and rules for medical practice in some countries in the region. Beyond legal and bioethical norms, it would be necessary to establish preventive control and accountability mechanisms, including moderate but effective sanctions, as well as compliance with the guarantees associated with due process, to ensure a

Responsible medical practice committed to the health of patients, with the duty and powers of the competent authorities to take measures that facilitate education and patient access to clear and objective information about their rights and the quality standards that should be expected in medical care.

Problem statement

The worrying occurrence of adverse events in healthcare centers, coupled with increasingly frequent lawsuits for malpractice and the concern for upholding the ethical principles established in codes and laws, such as primum non nocere and lex artis, have motivated this investigation.

Is medical malpractice solely a legal issue, or can it involve other factors related to professional ethics and skepticism regarding the lack of social effectiveness of sanctions (impunity/anomie) or factors related to the State's functions of provision, control, and supervision (service failures, lack of controls and accountability)? To answer this question, it is necessary to understand certain definitions, starting with an understanding of the concept of medical malpractice. According to Valverde (2001, 34), medical malpractice is conceptually accepted as "an unintentional, surmountable error, an error in the application of methods, techniques, or procedures in the different phases of a physician's actions, which result in a foreseeable impact on the patient's health or life."

From the statement of the concept, it can be deduced that there is a human factor that determines the occurrence of malpractice and its criminal legal consequences for the physician. However, other causes related to professional ethics that compromise other members of the healthcare team, educational and cultural factors in society, and even investment in healthcare policies may also be present.

Doctors are men and women; they are not deities, and they lack the power to cure or heal; they merely utilize well-established scientific knowledge through procedures, techniques, or medications that can alleviate the ailments of the sick individual. It is society, in its eternal search for a savior or messiah, that has contributed to the distortion of this image. Similarly, because medical science is inexact, even if a theoretically proven successful formula is used, it will not always guarantee satisfactory results. There are numerous underlying factors, such as genetic, environmental, immunological, undiagnosed or unknown underlying diseases, and the patient's psyche, that can influence the outcome of an illness. Is society aware of this fact, or does it, on the contrary, cling to cultivating and idolizing the image of the doctor as omnipotent, and when its expectations are not met, occasionally accuse him of being a murderer or charlatan, resorting to defamation and litigation?

Decorum, honesty, altruism, and moral integrity constitute standards that should shape and guide the conduct of physicians. Teaching and ongoing research are a constitutive part of medical practice, and their implementation is inscribed in the oldest traditions and social efforts of the highest-level corporate guilds. Therefore, their guidance and oversight are based on the most important ethical principles of our time.

It is reasonable to assume that medical errors and malpractice are of great relevance at the national and international levels, so their study is of vital importance. Their analysis must be in-depth, as well as the cause/effect relationship, in order to find points of agreement that allow for the establishment of strategies aimed at improving the relationship between the patient, their family and social environment, and the physician and the rest of the health team in an environment with a real investment in public health.

The right to health implies the satisfaction of an essential basic need, which in turn guarantees the exercise of all other rights. This is the case of integral human development, both individual and collective, which requires providing the population with a minimum quality of life through environmental sanitation, health policies, and, of course, the enjoyment of excellent health services. This requires promoting the educational function by disseminating information on malpractice, encouraging the legal establishment to be more familiar with the factors and consequences that determine it, and, in turn, facilitating the work of judges when issuing sentences.

Identification of the object of study

Location

The object of this study is fundamentally medical. However, it is linked to law, ethics or bioethics, technology, and society with regard to the social effects of the phenomenon. The approach we have proposed is essentially bioethical, with sociological approximations.

Purpose

Scientific and technological advances have neither eradicated nor reduced medical malpractice. This phenomenon has not lost its relevance. Occasionally, we observe episodes of medical practice outside the limits of competence, medical intrusion, as well as shortages of personnel, supplies, and work equipment adequate for healthcare provision in both the public and private sectors. Likewise, in the collective unconscious, there persists a belief of sacred or religious origin that the healing of a patient is an absolute right; therefore, a medical act can only have an infallible result.

Is medical malpractice considered a disvaluable behavior by society?

Defensive medicine refers to the practice of physicians taking additional measures, such as unnecessary tests and procedures, to protect themselves against potential malpractice lawsuits. This practice, according to Cruz-Valiño (2019, p. 109), has become increasingly common due to the rise in malpractice lawsuits and insurance premiums for physicians. However, defensive medicine can have negative consequences, such as unnecessary radiation exposure and other risks associated with unnecessary tests and procedures. Both defensive medicine and medical malpractice are related, resulting in lower quality of medical care and increased costs.

It is possible that defensive medicine could lead to an increased likelihood of medical malpractice, as physicians would be more concerned with protecting themselves from potential lawsuits than with providing the best possible treatment to their patients. However, medical malpractice can occur independently of defensive medicine, leading to serious consequences for patients.

Now, can we speak of a middle ground, of an ineffective functioning of the medical act, of the possibility of physicians self-regulating with ethical behavior? Is it possible that the Law can achieve this with its prudence, and bioethics with its intersubjective nature function from the faculties of medicine in training and in the committees of medical centers and colleges? These are some of the factors that we proposed to address in the development of this research, to favor the educational function of bioethics and medical responsibility and to encourage both physicians in their work of providing the best quality of life to patients, and the Judiciary in its function of administering justice, the logic of being more in tune with the factors and consequences that determine that

Certain medical errors lead to medical malpractice, making the work of those who must administer justice and those who have the responsibility of ensuring good practice easier.

Hypothesis formulation

Fundamental hypothesis of this research

In the practice of medical science, factors may coexist under certain circumstances that lead to failure of the medical procedure, causing harm to the patient and their loved ones. This undesirable outcome is largely expressed as a medical error, which can be corrected when recognized and corrected in a timely manner. However, if not, and in a percentage that is difficult to estimate, it can result in malpractice, specifically when evidence of incompetence, negligence, or failure to comply with existing rules and regulations is demonstrated.

Operational or working hypotheses

Negligence, inexperience, imprudence, and failure to observe standards, techniques, and regulations could act as triggering factors for the failure of medical decisions for the patient and result in malpractice. However, there are other causes that can influence the harm suffered by a patient; these do not depend directly on the physician's attitude, but rather on administrative factors at the health center, social and political aspects, and even those inherent to the patient or their family members. Both the public and private practice of medicine pursue the primary objective of curing the sick, providing them with full health; however, the results of medical practice are not always the most desirable, and a failure in diagnosis or treatment can end in a dismal outcome.

GENERAL AND SPECIFIC OBJECTIVES

General objective

To evaluate a sample of cases of medical errors in university health institutions in the metropolitan area of Caracas and their subsequent judicialization between 2015 and 2018, through criminal and civil complaints, to determine the causes that favor the emergence and frequency of medical malpractice, that is:

(i) impunity and the resulting social skepticism of punishment and anomie due to the certainty of the absence of sanction; (ii) dehumanization and commodification of medical acts; (iii) union solidarity and the absence of ethical sanctions by medical associations; (iv) shortcomings or deviations in university bioethics teaching; (v) failures in health services and in state supervision and surveillance.

Specific objectives

1. Analyze human factors, including the dehumanization and commercialization of medical practice, the security of impunity, and the lack of awareness or relativization of the importance and enforceability of bioethics, which may contribute to the consolidation of medical malpractice.

2. Describe social factors such as anomie and the lack of social effectiveness of punishment, union factors such as automatic solidarity, governmental or state factors such as impunity and failure of service, and educational factors such as deficiencies in bioethics training and the presence of implicit codes that induce professional practices outside of bioethics linked to medical malpractice.

Inclusion criteria

The research will include several groups of male and female physicians with different levels of training and specialties, years of graduation, and experience in medical practice, who work in public hospitals certified with university postgraduate degrees in the city of Caracas and who voluntarily agree to complete the anonymous survey. With the same objective of gathering information on medical malpractice, lawyers and patients or their families will be asked to complete the survey. Lawsuits with final judgments for medical malpractice with relevant content, which appear on the web during the period 2015-2018, will be selected.

Exclusion criteria

Physicians, lawyers, patients, or their relatives of either sex and with the same characteristics as the previous group who, for various reasons, refuse to respond to the survey, as well as those working in private health centers in Caracas, will be excluded from this study. Given the secrecy of these institutions and their poor accessibility, this study is aimed at university-based professionals. Health professionals from university hospitals will be evaluated, excluding institutions offering postgraduate programs or scheduled non-university care residencies. It should be noted that information concerning private practice could be obtained indirectly, considering that most physicians combine public and private sector work. Lawsuits with final judgments involving causes other than medical malpractice will be excluded.

METHODOLOGY

The methodology used in the research was the result of the complex conjunction of various systems, highlighting the inductive and deductive, qualitative, bibliographic and monographic methods to examine malpractice.

Medical malpractice, with the aim of improving its understanding, was based on the criteria of both recognized authors and its own, and was oriented toward decision-making and the development of conclusions. Part of the data was obtained from a review of so-called secondary sources. Given that the surrounding aspects that influence the crystallization of medical malpractice are multiple and the problems inherent to it can vary from one continent to another, both national and foreign doctrine were consulted.

This research contains elements that categorize it as explanatory, descriptive, and correlational. The degree of abstraction of the thesis was applied research, whose main objective was to resolve a practical problem such as malpractice, with a limited scope for generalization. Its chronological dimension was based on the current situation, and it was a cross-sectional study. (Hernández, 2010, 52)

An attempt was made to describe the reality of the incidence of medical errors and, consequently, medical malpractice in university health centers in Caracas. At the same time, the complaints and lawsuits to which doctors are subjected were compared when they allegedly commit an error that ends in negligent injuries or homicide in a specific case. This coincides with fieldwork because it characterizes a specific temporal and spatial reality. Knowledge and experience were also evaluated through an anonymous survey, as well as complaints and lawsuits against those doctors involved in cases of medical malpractice that have been presented to the Medical Association of the Metropolitan District of Caracas, the Management of the Health Center where the incident was evidenced, or the Public Ministry of the People's Power for Health. The survey was also conducted with lawyers working at the Central University of Venezuela (UCV) and with victims of medical malpractice.

The thesis adhered to the guidelines established in the manual prepared by the Graduate Studies Committee of the Faculty of Law and Political Sciences. It had a qualitative approach because selected data were analyzed to provide depth to the topic, contextualization of the environment, details, and unique experiences, inscribing itself within the sociological current of legal research.

In the opinion of Witker (1996,75) legal norms are not dead entities, which are separated from social life to be analyzed and described autonomously, they constituted a process, where the search, selection, reading, registration, organization, description, analysis and interpretation of the data obtained were part of its structure, all with the purpose of finding answers to the questions raised.

A complementary survey, designed and evaluated by experts, provided data on the three study groups: lawyers, victims, and physicians, which coincided with an exploratory study. Interviews were conducted with professors specializing in different branches of law from the Faculty of Law and Political Sciences (FCJP) at the University of Valencia (UCV) to obtain their opinions, points of agreement, and disagreement. From the analysis of lawsuits resulting in a final judgment, salient aspects were extracted and linked to the rest of the documentary structure of the work.

CHAPTER Yo

FACTORS ETHICAL GENERATORS OF MEDICAL MALPRACTICE

Medicine is a profession that goes beyond science and technology. It is an ethical act, a social responsibility, a commitment to the well-being and dignity of our fellow human beings. Medical practice as an ethical act implies absolute respect for the life, integrity, and autonomy of patients. It is the constant pursuit of professional excellence, but also compassion, empathy, and humane treatment. Physicians must not only cure diseases but also alleviate suffering and provide comfort and hope. In this first chapter, we aim to address some essential elements that will help us understand this complex topic throughout our work.

In this sense, altruism plays a fundamental role in medical practice. The vocation to serve others, to put the patient's interests above one's own, is the foundationThe growth of medical practice as an ethical act. It is the commitment to put the human person at the center, to care for their health and well-being, regardless of age, race, gender, or socioeconomic status. However, this noble act is exposed to various threats and challenges. One of these is medical errors and malpractice, which endanger the lives and health of patients. Bioethics emerges as a tool to reflect on these ethical issues, proposing principles and standards that guide responsible and safe medical practice.

At the same time, union solidarity is essential to ensure quality medical practice. Physicians must unite and support each other, sharing knowledge, experiences, and best practices. This solidarity not only strengthens the medical profession but also benefits society as a whole. However, it could have a double meaning, as it could serve as a cloak of immunity to hide medical malpractice crimes. Unfortunately, in many cases, medical practice is affected by poor service, media persecution, anomie, and impunity. The lack of

Lack of resources, social pressure, and deficiencies in health systems can lead to situations in which doctors are overwhelmed by their skills, committing unintentional errors, or even becoming victims of injustice.

It is the responsibility of physicians, lawyers, academics, and society at large to foster a culture of ethics and responsibility in medical practice to ensure humanistic, caring, and safe medicine for all. In the following pages, we will delve into concepts and explore specific cases in which these principles have been put to the test.

1.1.-Conceptual framework 1.1.1.-Medical malpractice

In the opinion of Arteaga (1991,34) medical malpractice is understood as: "…incorrect action in the exercise of the medical profession, capable of causing harm to the patient."

We believe that medical malpractice refers to negligent or inadequate medical care that causes harm to the patient. From a legal perspective, medical malpractice is considered if it is proven that the physician failed to meet professional standards of medical care and caused harm to the patient.

1.1.2.-Bioethics

According to Obiglio (1998, 22) bioethics is the systematic study of human behavior in the fields of biological sciences and health care, to the extent that this behavior is analyzed in light of moral principles and values.

The term bioethics was used by Van Rensselaer Potter in 1970 to refer to the systematic study of human behavior in the area of science.

and healthcare, as soon as this conduct is examined in light of moral values and principles." All ancient documents and oaths agree on the following ethical principles: Do no harm to the sick, respect the sanctity of human life, alleviate human suffering, and there will also be sanctity in the doctor/patient relationship, which is reflected above all in professional secrecy and in not taking sexual advantage of it. In 1972, a document called "The Patients' Bill of Rights" in private American hospitals became widespread and became a mandatory requirement for accreditation of any hospital. The basic pillar of the patients' bills of rights was informed consent, favoring a horizontal, and not vertical, relationship between those with medical or nursing knowledge and the human being affected by the disease.

Now, there would be a hierarchy of ethical principles, in such a way that we would find several levels:

Level 1: Non-maleficence and justice, is the level that we can call minimum ethics, in which we can be forced from outside, because it regulates the common good, it refers to perfect obligations that generate transitive negative duties, that is, what should not be done to others, and socially it would be regulated by Law.

The principle of non-maleficence demands respect for the assets and values of the person, while the principle of justice demands that every human being be treated in their personal dignity, always as an end in themselves and never merely as a means, and that they not be discriminated against for economic, racial, or religious reasons.

Level 2: Autonomy and Beneficence. This is the highest level of ethics and is related to the life plan that each person freely chooses in the pursuit of happiness and the realization of their own values. It refers to the so-called imperfect obligations, which I can demand of myself, but which

I cannot impose on others. In the opinion of Torregosa (2005, 212) "this level would correspond to the study of morality, the good action that responds to social beliefs and convictions and is freely exercised"; and ethics understood as the discipline that reflects on these social beliefs and convictions seeking to explain their foundations guided by common ideas of justice and bioethics that seek to analyze and argue interdisciplinarily, dilemmas that affect life in all its breadth in the face of increasing technological development. American Bioethics gives greater emphasis to the principle of autonomy over that of beneficence, which is the area of Latin influence.

Biomedical research involving humans is a complex activity. Bioethics Committees are bodies charged with ensuring that their progress does not harm the physical and moral interests of those involved. Their fundamental objective is to align medical practice with the moral values that legitimize it. They are multidisciplinary groups created specifically to help healthcare personnel resolve the ethical dilemmas and conflicts posed by modern medicine. There are several types of committees:

1) Clinical Research Ethics: Its primary purpose is to ensure the quality of studies and protect subjects in a clinical trial; that is, in any experimental evaluation of a substance, medication, or technique during which these are administered or applied to human beings.

2) National Bioethics Committees: These are created by a country's highest government authority, the president or prime minister, to advise on various bioethical issues that arise.

3) Healthcare ethics: Healthcare ethics committees arise as a result of the need for physicians to share decisions that affect patients' quality of life and that carry the risk of uncertainty, both due to the foreseeable results of certain therapies or interventions, and due to the assessment of risks and benefits.

In order to obtain fair and appropriate solutions, in the analysis of each case, the committees are required to consider various factors, namely:

a) Correct clinical history

b) Clarification of the clinical problem

c) Possible treatment alternatives

d) Consideration of the ethical dimensions that refer to problems related to quality of life, among others. Those non-clinical factors, mostly economic-social always they have of have special consideration in a medicine that HE price of be Comprehensive. Fundamentally, the ethical values of civil society are: freedom, equality, solidarity, justice, active respect, and an attitude of dialogue. These values are the basis of civic coexistence and constitute an ethical benchmark.

1.1.2.1.- Bioethics and Law

In Scala's view (2004, 3), "Bioethics is the ethics of human life and of the practical and technical knowledge related to it: medicine, genetics, embryology, and genetic engineering, among others." That is, bioethics cannot have first principles different from those of ethics; that is, it is merely an ethics applied to specific knowledge and action.

The principles of bioethics can only be secondary, and are those precepts that derive from the application of the first ethical principles to the practical and technical sciences related to human life. Consequently, the true principles of bioethics could never contradict the first ethical principles, and any pseudo-bioethical principle that did so would be nothing more than a false principle. The real difficulty of applying an abstract principle to a concrete problem is a different matter; difficulty does not imply a contradiction, but only the need for greater effort to achieve the desired result. (Scala, 2004, 3)

Ethics, and consequently bioethics, cannot be separated from law as if they were unrelated elements. Law, as the just ordering of society, must be based on true moral norms; otherwise, it would fail to achieve its purpose. This relationship, when correctly interpreted, is fundamental, since otherwise one of two pernicious things would happen: a) if ethics were not reflected in legal norms, society as a whole would be left to the good or bad will of its citizens; or b) if legal norms were not in line with ethics, injustice would spread throughout society.

However, the ordering of society cannot be subject to the decisions of the strongest, according to their particular interests. There are only two options: either society opts for the force of law, or else it falls into the "law" of force. And the ultimate foundation of the ethicality of law is provided by the order of nature itself; that is, a system of legal norms in conformity with the natural order implies an ordering in accordance with ethics. (Scala, 2004, 3)

1.1.2.2.- General ethical and bioethical principles

Some aspects of the natural order are directly related to the topics addressed by so-called bioethics. First, all the general principles of right human action apply to it, such as: “one must do and strive for good and avoid evil”; “no one must be unjustly harmed”; “giving to each his due” (justice in the broad sense); and honeste vivere (living honestly), according to Ulpian's characterization, which refers to the honest good, that is, that objective good, which is both for the subject and also for other men, or at least some of them, and which cannot be an objective evil for anyone. From these general and absolute principles that admit no exceptions, other principles are derived.

Principles that serve to regulate certain particular aspects of human intervention (ethos) in relation to life (bios). (Scala, 2004, 4)

1.1.2.3.-The derived ethical principles

1.1.2.3.1.- The right to the inviolability of human life

A close look at human nature reveals the inviolability of human life, or better known as the “right to life,” inscribed in the heart of every well-disposed person. According to Scala (2004,5), “this right is not absolute, since the human life of the guilty party would not enjoy the prerogative of inviolability, according to the legislation of the country where the crime was committed. Indeed, self-defense has been recognized since time immemorial as a just limit to the right to life, and the death penalty as a legitimate defense of society against the guilty party who commits a crime. On the other hand, the right to the inviolability of life of every innocent human being is absolute, and this is one of the preliminary principles derived from bioethics.”

Regarding the initial moment of human life, biology comes to our aid and teaches us that fertilization (penetration of the male sperm into the female egg) begins a process that is irreversible in itself, which concludes with the formation of a being belonging to the human species; a person who will be unique and unrepeatable even in their biological aspects. Scala (2004, 6) continues, “even granting that someone could doubt the beginning of human life, precisely because it is the substrate that allows the exercise of every other right, the ethical and legal principle must be adopted that, in case of doubt, it would be obligatory to take the most remote moment in which the doubt begins –in dubio pro vita– and this cannot be other than the beginning of fertilization, a moment that is designated by the term

legal “conception”. If in dubio pro reo or in dubio pro operario are accepted, with much greater justification should in dubio pro vita be accepted.”

Scala (2004, 6) states: “…Regarding the final moment of human life, science has not been able to define it as clearly as its initial moment. This undoubtedly poses some difficulties to the bioethical problem of organ transplants. However, this derived bioethical principle could be summarized as: “all innocent human life is inviolable, from the initial moment of fertilization until natural death.”

1.1.2.3.2.- Right to physical integrity and health

The specific principles of bioethics are related to the right to physical integrity and health of every human being. Indeed, the preservation of life necessarily implies maintaining, to the extent possible, bodily integrity and health. Analogously to the "right to life," this is not about affirming a supposed right to immortality or "complete well-being," because naturally every person must die and before that, will suffer from illnesses and physical ailments. It is about immunity from external aggression by other people that threatens the physical integrity and health of every human person. (Scala, 2004, 6)

However, this inviolability of physical integrity and health would have three very clear exceptions: a) one of them is the principle of totality, according to which, as long as there is no other therapeutic method, it is admissible to save life, or provide better physical integrity (the whole), to sacrifice some part of the body (the part); the obvious example is the amputation of a gangrenous limb to save the life of the patient; b) the second is the principle of actions with double effect, according to which it is lawful to act when an action results in two effects, one good and the other bad, and between both, the good is the desired one (intention) and the one carried out (objective act), and also, it mediates between

both effects equality of goods as a minimum, or that the good effect is a greater good than the loss entailed by the bad effect (just cause) or also known as (risk-benefit); also, that there is no other less burdensome means of obtaining the good result. This derived principle is used, for example, to resolve the bioethical dilemma of ectopic pregnancies, where the embryo will die irremediably and with its growth outside the womb puts the life of the mother at risk, and c) the third is the principle of charity, by which it is lawful for a living person to donate organs for transplants, as long as they do not entail the death of the donor. (Scala, 2004, 6)

1.1.2.3.3.- Crisis in the application of bioethical principles

In Scala's opinion (2004,6) "...The application of the principles of bioethics could entail dangers derived from the conjunction of the dogmatic "principles" of bioethics with the broad concept of health. They could be considered as tools to impose certain purposes such as the change of moral and ethical standards of people and human societies. For example: the principle of autonomy could be used to justify "bioethically" that a woman voluntarily interrupts a pregnancy, or the broad notion of health added to the principles of beneficence and justice, could be used to authorize sterilizations without therapeutic indication. "

1.1.2.3.4.- The twilight of human life

In the opinion of Scala (2004,6) "…The decriminalization of euthanasia in Holland was initially carried out as a partial reform of the law in 1993 and on April 10, 2001 in a virtually absolute manner, being supposedly justified by its mentors with the pseudo-principle of autonomy, and with the hackneyed term "quality of life", according to which the

People lacking certain abilities or suffering from certain illnesses would fall below the standard of living considered minimum, and therefore, according to the promoters of euthanasia, the best thing that could be done for their benefit would be to eliminate them gently. What the defenders of these practices, frontally contrary to true bioethics, fail to mention are the real economic motives that seem to support them. It is a crying truth that the world's social security systems are in a crisis that will soon be terminal. Indeed, the sharp drop in birth rates, coupled with the increase in life expectancy, both phenomena that have occurred in all countries of the world, although with nuances in terms of their intensity, have had a devastating effect on social security.

It is well known that there are fewer and fewer active workers and more passive ones, in processes that have been going on uninterrupted for decades. Furthermore, Scala (2004, 7) continues to argue: "…it is known that, in general, the elderly are those who spend the most on health. The processes of "rationalization" of health spending also pass through the coordinates of the pseudo-principle of justice, understood only in socioeconomic terms, that is, if health resources are insufficient, they should be allocated to human beings who offer greater "social utility." For this reason, euthanasia has been legalized in some parts of the world. This would contravene not only Hippocratic principles, but also the thinking of Dr. Luis Razetti (2010, 12), who stated: "…I will carry out my profession with care and dignity, ensuring the utmost respect for the lives of my fellow human beings, and even under threat, I will not use my knowledge to contravene the laws of humanity."

1.1.3.-Medical error

In the opinion of Alvarado (2009,15) "Themedical errorIt is any failure that occurred during health care that has caused some type of harm to the patient,

and whose origin can be related to the organization and implementation of the service, through multiple and complex mechanisms. No specialtymedicalis exempt from it."

We consider a medical error to be a mistake in the diagnosis, treatment, or prevention of a disease that may have harmful consequences for the patient. From a legal perspective, a medical error may be considered medical malpractice if it is proven that there was a failure to follow professional standards of care.

1.1.4.-Anomia

According to Besnard (1987,35) "Anomie is a concept from the theoretical tradition of sociology that means the absence of norms, the tendency to break rules, both at the collective level, when a severe crisis in the social structure breaks existing norms and new ones are not yet consolidated, or also at the individual level when they are not permanently complied with." The concept was originally introduced by one of the founding fathers of sociology, the Frenchman Emile Durkheim, into the conceptual arsenal of this discipline.

Anomie is defined as the lack of clear rules or confusion about what is right or wrong in a given situation. In the medical context, anomie could arise when there are no clear guidelines on how to handle a specific medical situation.

1.1.5.-Union solidarity

The College of Social Workers of Costa Rica maintains that (1969,21) "Solidarity plays a role of primary importance for professional work, since it offers the conviction that the activity carried out is sufficiently important to ensure the worker's satisfaction.

of his own realization as a human being, the realization of his vocation and, in general, the happiness of serving others through kind acts for the love of one's neighbor.

We consider professional solidarity to be the belief among members of a profession in the responsibility to support one another and protect the interests of the profession as a whole. In the medical context, this could mean supporting a colleague accused of medical malpractice or providing emotional and professional support to a colleague who has committed a medical error.

1.1.6.-Impunity

Considering its etymological origin, although in a negative sense, in the opinion of Bonet (2009,23) the term impunity "directly manifests the retributive quality that, among others, characterizes the law: the lack of punishment, if such perception is projected on criminal law, it could be stated that, generically, impunity is constituted by the absence of prosecution and criminal sanction with respect to typified criminal conduct."

We believe that impunity in fact refers to the lack of real consequences for those responsible for medical malpractice crimes, even when it is known that they have committed an error or acted negligently that caused harm to the patient. Impunity in law, on the other hand, refers to the lack of effective enforcement of existing laws to punish these crimes. Both forms of impunity are troubling and must be addressed to ensure justice and protect patients.

1.1.7.-Impunity and social ineffectiveness of the norm

Impunity and the social ineffectiveness of the norm are two different concepts, the first refers to the lack of punishment or sanction for a criminal act or

Illegal, that is, when someone commits a crime and is not punished by the authorities, this can be the result of several factors, such as the lack of resources of the authorities to investigate and prosecute those responsible, corruption, lack of independence of the judiciary, among others. On the other hand, the social ineffectiveness of the norm refers to the lack of compliance or practical results of the laws and norms established by the State. That is, although there are laws and norms that seek to regulate people's conduct and protect their rights, in many cases these norms are not complied with or are not applied effectively. The ineffectiveness of the norm can be the result of several factors, such as a lack of education and citizen awareness, a lack of resources and capacity of the State to enforce the norms, among others.

The concept of impunity has gained particular relevance in the international community due to the serious human rights violations that have occurred throughout history and gone unpunished. Today, this concept is no longer related solely to the absence of punishment, but also to the existence of the rule of law and the effectiveness of judicial bodies.

For Escobedo (2013,30) “The 1996 Santiago Declaration sought to achieve a definition that encompassed the concept of impunity, concluding that impunity was, in the immediate sense, the renunciation of criminal sanctions for those who violate human rights, and that its consequences affected society as a whole. In short, it was the institutionalization of injustice by those who are called to do justice.”

From the above, the following elements can be observed: a) waiver of criminal sanctions for violators of protected legal rights by their own will or imposed by force; b) institutionalization of injustice by those who are obliged to do justice, that is, denial of justice. c) by

Finally, this definition states that its consequences affect society as a whole.

Impunity constitutes a violation of the obligations of States to investigate violations, to take appropriate measures against their perpetrators, particularly in the area of justice, so that those suspected of criminal responsibility are prosecuted, tried, and sentenced to appropriate penalties, to guarantee victims effective remedies and reparation for damages suffered, to guarantee the inalienable right to know the truth, and to take all necessary measures to prevent the recurrence of such violations.

Punishment is the possible consequence of committing a crime, and its necessity responds to the preservation of the social order for which individuals have entered into a contract by ceding part of their autonomy, placing the State as the primary party obliged to provide this order.

The absence of punishment for the commission of a crime can occur in two different circumstances: The first is when the crime is not brought to the attention of the authorities and they have no indication of its commission. The second is when, despite the authorities being aware of the crime, it is not investigated to determine the culprit and the knowledge of the truth about the circumstances in which the crime was committed, or when it is investigated, it is not punished by the authorities, either by virtue of a legislative act that exempts the guilty party from criminal liability or by virtue of a personal law (judgment or resolution) by which the guilty party is exempted from the same responsibility without a valid legal basis.

The former are known respectively as impunity in fact and impunity in law and respond to a broader concept of general impunity. "De facto" impunity derives from the weakness of institutions, especially the judiciary, fueled by acts that hinder

The conduct of proceedings or undermine the independence and impartiality of justice. This often results in the refusal of security forces to provide the evidence necessary to identify the perpetrators of human rights abuses, the reluctance of officials allegedly involved to testify in court, the falsification of public records, or the intimidation and threats directed at victims, judges, lawyers, and witnesses. Furthermore, impunity "as a matter of law" occurs due to flaws in legislation, such as the failure to criminalize certain behaviors, the failure to provide amnesties or pardons, or the imposition of disproportionately low penalties in relation to their severity.

1.1.8.-Media trials

The literature has described how, in nations where an environment of extreme social crisis and crime prevails, citizen security could be threatened by the inability of states to punish, prevent, and repair the harm caused to victims while respecting and guaranteeing human rights. The consequences of this stagnation in the ability to prosecute are regrettable and create a vicious cycle in which citizens, as never before, refrain from reporting due to the perception of impunity prevailing in the institutions of justice. Meanwhile, these institutions assume a tyrannical power to systematically revictimize both the accused and the victim through illegal and arbitrary acts that completely defy the appropriate procedural means to guarantee both parties true access to justice.

In these situations, society's right to be informed promptly and truthfully on security matters is frequently violated.

citizen, since we live in an environment that contributes to the creation of judgments by the media, which reproduce in an erroneous or distorted way partial and subjective information of the judicial cases that the agency itself makes available to them, thus generating the feeling of impunity and insecurity in the population to justify the application of heavy-handed criminal policies that only favor repression, intolerance and stigmatization and do not resolve the real problem, representing a serious setback in the validity and effectiveness of human rights.

Taking into account the above, Barata (2012, 44) notes that "…Historically, the public exposure of prisoners has been possible because those who have exercised power also dominated the ritual of punishment, which had to be shown, designated, stigmatized; they controlled the enunciation of evil, the discourse and the symbolism of the penalty. While the spectacle of punishment has been the mark of tyrants, contemplating how judges dispense justice is a sign of civilization." It would be Cesare Beccaria, writer, philosopher, jurist and economist, who would have indicated two and a half centuries ago: "Let trials be public, so that the people believe in the law" and it is precisely the orality and publicity in the hearing where it is appreciated how justice is administered, but also because it is the only moment of legal truth where the process and the evidence presented are validated." (Beccaria, 2000)

Only then can the accused be considered guilty, if the judge so decides. Beccaria also reportedly stated that a man could not be declared guilty before the judge's sentence, nor could society withdraw public protection from him.

After many years, the presumption of innocence is finally considered a universal right, there is no fair justice possible without the process being carried out with all the guarantees, among them that it is not considered

The guilty party must be held accountable until proven guilty, and their right to defense must be respected. These are procedural principles that must be complied with by those who operate within the criminal justice system, otherwise they would be attacking what they themselves are supposed to defend and what they have been appointed to do. The presumption of innocence is one of the major achievements in the world of human rights and has been established in treaties and laws. Now, everyone claims to defend it, even if practices are distorted and the meaning we give to this statement is questionable.

Acota Barata (2012, 33) states that time sweetened physical torment with the cloak of humanism. Public torture, the display of pain, and the punishments of infamy gradually faded as humanity took the tortuous path of human rights, and with it, the light of reason consolidated the rights of the detainee. However, certain pleading shadows continue to be projected in the present. They are the ghosts of the past that do not want to lose the power they once had. The pages of history have taught us that the exhibition of the prisoner was a ritual promoted by tyrannical power to construct a certain truth that had nothing to do with legal certainty, much less with the right word. The goal was for the prisoner to judge and condemn himself in a game of illusory truths. We will never know exactly what motives have led us to be attentive spectators and accomplices in the rituals of crime, no matter how many learned psychologists and criminologists formulate seasoned theories, but we are increasingly certain that the exhibition of detainees is the remains of a shipwreck.

The progress in civil rights has been spectacular, but the practice of displaying detainees still persists in many places around the world, which suggests that the issue has as much to do with civil rights as with the democratic and social ups and downs around issues of justice and rights, without leaving aside the power of the rituals and symbols that shape them.

the collective imagination. The offender is no longer shown at the moment of punishment—hidden due to a certain social shame—but rather when people are arrested and accused of a crime. Now, the exhibition takes place before the media, which are the new promoters of public opinion, the new public square. A new punitive ritual emerges that would not be possible without the action of the press, a ritual that is perceived to conceal a similar intention to that which it had in ancient times: to offer an accurate representation of the subject who must pay for the crime, to make them the scapegoat for all evils, to focus on them the fears and insecurities, the demands for reparation so that the complex feeling of the crime is transformed into punitive desires. Evil is focused on a representation, and the media spotlight impacts society with its images, thus promoting the symbolic use of criminal law, where what matters is not the word of the dead but the handling of symbols. The aim is more to calm supposed public alarm than to effectively combat crime.

According to Barata (2012,54) “Through the use of these punitive rituals, popular demons that are so useful to the new punitive ethos are built; media messages end up becoming the perfect allies of the policies of intolerance and with them, indignation is promoted among citizens upon which heavy-handed actions are agreed upon and legitimized. Faced with such media treatment, the penal system becomes defensive and rights are regressed by blows of media impact.”

The new gallows now enjoys a publicity like never before in history. We don't see the spectacle of the penalty, nor how the line of prisoners marches through the towns and cities, but from the intimacy of our homes, we watch on television and on the front pages of newspapers a shocking ritual, constructed with dramatic language that anticipates the penalty.

Contingent. The media, especially television, end up imposing the "truth effect," that is, making people see and believe what they make people see. Preemptive punishment is cultivated, the same process that underlies acts of lynching. There is a remote but disturbing connection between the treatment of the detainee during their exhibition, the way they appear in the media, and acts of collective violence. We might wonder whether certain media cruelties are not contributing to a vindictive discourse that acts as a spur to such social reactions. The responsibility of the media in the development of criminal cases is an issue that concerns legal scholars and human rights defenders, and one that journalists themselves are beginning to address, stemming from a new, barely acknowledged, unease related to ethical values. It is a debate that crosses the boundaries of procedural discourse regarding rights and duties. The guarantees that make the presumption of innocence possible transcend the legal sphere; it is not merely a matter of procedural mechanisms. It seems increasingly clear that the right to the presumption of innocence is being seriously affected by the media's actions based on certain institutional practices. This is a legally unresolved issue, since strictly speaking, this right operates only within the legal sphere, and what the media could affect are rights related to the protection of privacy, reputation, and good image.

Barata (2012,51) emphasizes that “In the current scenario, where the authority can expose someone to the media as soon as they arrest him without any legal formality, a perverse incentive is created to try to win the trial not in the judicial arena, where there should be a solid investigation and due process should be observed, but in the media arena to place in public opinion the idea that the authorities are being effective and are

responding to the population's demands for greater security, regardless of the results of the investigation.

If a media outlet projects images of a person allegedly under investigation for a crime, with weapons and gunshot wounds in the background, the subliminal message the media is sending is not an objective account, because journalistic and media languages, unfortunately, are neither neutral nor objective, and this is inevitable. Therefore, the fact that the authorities foster this scenario for the media to disseminate is irresponsible, because they are not creating a conscious, impartial, ethical, and responsible social communication policy that addresses the effects that will occur when the information is translated into media language.

The disadvantage of using media trials or media prosecutions to curb medical malpractice crimes is that they could hinder justice, which should be impartial and based on concrete facts and evidence. Media exposure should not replace or hinder the proper and fair judicial process, as it can generate bias and impair the objectivity of the process.

1.1.9.-Media persecution

In the world of medicine, when a professional makes a mistake that causes harm to a patient, they often face two negative consequences: media persecution and public ridicule. Although both terms are related to society's reaction to malpractice, they have important differences that are essential to keep in mind. The similarities and differences between the two concepts and how they affect doctors in malpractice cases are: Media persecution is a concept that refers to the wave of criticism and condemnation that a physician receives.

medical professionals through various media outlets following a malpractice incident. For example, if a doctor makes an error that results in the death of a patient, local newspapers, television, and radio stations may report on the incident and use it to cast doubt on the doctor's professionalism and competence. Public opinion is thus turned against the professional, and the professional becomes an object of scrutiny and criticism. Public shaming, on the other hand, is a concept used to describe the humiliation and shame suffered by a medical professional following a malpractice incident. This type of consequence can be especially painful for the affected doctor, as it involves public exposure of their error and a potential loss of reputation and respect in their workplace and society. For example, if the doctor's error is reported in the media, the doctor may be publicly acknowledged, which can cause them to feel ashamed and stigmatized.

Although both terms have negative consequences for the affected physician, there are some important similarities and differences between them. First, both media harassment and public ridicule stem from a medical error, meaning the affected professional is seen as guilty and responsible for the damage caused. Furthermore, both phenomena have the potential to damage the physician's reputation and career, which can have serious consequences for their future employment.

Regarding the differences, the main one is that media persecution is related to the publication of the news in the media, while public ridicule refers to the treatment the affected doctor receives in his or her work and social environment. That is, while media persecution focuses on the impact that the news of the incident has on public opinion,

Public ridicule refers to the treatment that a doctor receives from his colleagues, friends, and family.

1.1.10.-Service failure

In the opinion of Guerra (2015,41) "The failure in the service is nothing more than a theory of responsibility to justify the State when it causes damages as manager of public services, derived from the principles of civil law that enshrines the responsibility for damages due to the negligent acts of its employees, it is revalued by the new conception that wants to base the culpable responsibility on a primarily objective concept, equivalent to the duty of the State to repair the damages caused to citizens by the inadequate functioning of public services, in secondary consideration to the lack or fault attributable to the agents legally in charge of putting those services into operation."

Regarding service failures in public and private institutions, it is important to keep in mind that there may be various causes behind these failures, such as lack of resources, poor management, or corruption. In any case, these failures can contribute to situations that lead to errors or medical malpractice. In legal terms, according to Dudamel (2007, 52), institutions and their staff may be held administratively, criminally, civilly, or ethically responsible for these failures if it is proven that they played a role in the situation.

Service failure in public and private institutions can have serious consequences for health care. We believe that a lack of supplies (catheters, medications, or intravenous solutions), as well as a lack of medical personnel, could lead to medical errors or malpractice. For example, a lack of medical personnel or work overload could cause fatigue and stress in patients.

healthcare professionals, which would lead to errors in diagnosis or medication administration, while the lack of supplies would also cause medical professionals to improvise or use inappropriate materials, increasing the risk of errors and complications.

In legal terms, these situations can have several repercussions. First, they can generate administrative liability for healthcare institutions and those responsible for their management. If it is proven that there was a lack of foresight or management in the supply of supplies, the institutions could be sanctioned by health authorities. Furthermore, if these situations have caused harm to patients, there could be criminal consequences for the professionals involved. If it is proven that the medical errors were caused by negligence or recklessness on the part of medical personnel, they may face criminal charges for medical malpractice.

Regarding civil liability, if medical errors are proven to have caused harm to patients, the institutions and staff involved may be sued by the affected individuals or their families. In these cases, the institutions may be required to pay compensation or financial compensation.

Ethically speaking, failure to provide service in healthcare institutions can be considered a serious offense. Healthcare professionals have a responsibility to ensure the safety and well-being of their patients, so any situation that puts their health at risk should be addressed immediately and appropriately.

Ultimately, service failure in public and private institutions can have serious consequences in the health field, including situations that lead to errors or crimes of medical malpractice.

These situations can generate administrative, criminal, civil, and ethical liabilities for the institutions and personnel involved. Therefore, it is essential that appropriate measures be taken to prevent these situations and ensure patient safety and well-being.

1.1.11.-Jurisprudence

Jurisprudence has been a widely studied subject. However, a number of questions arise. The first of these is to define a concept, since jurisprudence cannot be defined in a single sense. There is no single meaning of the term jurisprudence, but rather a plurality of meanings depending on the historical moment or era (a temporal variable) and the place or legal system in question (a spatial variable).

For Falcón (2010,75) “The word jurisprudence is not a univocal term, but it is possible to attribute a plurality of meanings to it. In a first meaning, we could understand it as the Science of Law. This is the concept of the term existing in Roman Law, as writings of the iuris prudentes or those knowledgeable in Law. The definition of jurisprudence given by Ulpian in the Digest as divinarum atque humanarum rerum notitia, justi atque injusti scientia, that is, as knowledge of divine and human things, science of what is just and what is unjust, is classic in this respect.”

The word jurisprudence has the same meaning as the Science of Law in the Anglo-Saxon and Germanic worlds. However, unlike the German authors who developed Jurisprudenz and the Anglo-Saxons and their conception of Jurisprudence in ancient Roman law, iurisprudentia is not equivalent to the modern concept of the Science of Law, but rather to the notion that Roman law had of it. The origin of the Latin word iurisprudentia is found in the expression, also Latin, prudentia, which constitutes, in turn,

a translation of the Greek term phronesis (practical wisdom or prudence) as the assessment and knowledge of what is just and what is unjust, with the aim of practicing the former and avoiding the latter. From the Latin word iurisprudentia come similar terms and expressions in other European languages: jurisprudencia in Spanish, jurisprudence in French, Jurisprudenz in German, or iurisprudentia in Italian. However, despite the fact that we say that Roman iurisprudentia was equivalent to the Science of Law, we are not referring here to what we understand today as science, for which the Romans did not have an adequate term, other than scientia, as simple knowledge, or ars as technique or system.

Falcón (2010,80) argues: "We can affirm that Roman iurisprudentia was not intended to investigate a scientific truth through a logical construction, but rather to obtain a practical result, namely, the application of justice in social relations. Science was not conceived separately from life, but rather at its service. The iurisprudens was not a technician or a specialist in a certain scientific field, but rather a person who acted prudently in the field of law. Perhaps this is why the first jurists were the Pontiffs, since originally, since law and religion were fused, priests were considered the most just and prudent people. To achieve its goal, Roman jurisprudence made use of all types of knowledge: religion, morality, philosophy, history, philology, rhetoric, etc. The jurist used all of them. Hence the definition of iurisprudentia in Rome as divinarum atque humanarum rerum notitia. Later, the notion would be limited to the legal sphere, separating itself from religion and morality."

Thus, in the time of the Roman Republic according to Falcón (2010,83) "... the opinions of the jurists did not have binding force for the judges, having simply the force derived from the prestige or authority of its author, over time, the emperors, seeking to take advantage of the

The undeniable value of the institution of jurisprudence created the ius publicae respondendi or ius respondendi ex auctoritate principis: initially, any author who found himself qualified to do so could issue his opinions in the name of the emperor ex auctoritate principis. It was Augustus, the first Roman emperor, who, in order to give greater luster and dignity to the institution, limited the right to respond to a small group of enlightened jurists. It was the jurists who later had to request the prince to grant the ius respondendi as a privilege. The practical resolutions of these jurists privileged by the emperor eventually acquired the force of laws binding on the judge. The value of these responsa of the jurists did not derive in the monarchy from their personal auctoritas, as occurred during the time of the Republic, but from the auctoritas of Augustus. This led to a certain reduction in the freedom enjoyed by jurists during the Republican period and a greater connection to imperial criteria. Such was the authentic nature of these responsa as a source of law in Rome that judges rarely deviated from the criteria of a jurist with ius respondendi.

In this sense, the force of the responsa was even greater when several jurists agreed on the same solution they proposed. On the contrary, in the event of divergent opinions, the judge could follow the one he deemed most pertinent. While the ancient republican jurists adhered rigorously to tradition and rarely deviated from the letter of the law, in classical times they proceeded with greater ease and freedom, guided more by the spirit of the law, placing themselves, to a certain extent, above the law or, at least, above a grammatical or literal interpretation of it, as opposed to what happens today with judges, at least in the continental system. Perhaps never in the history of law have jurists had such influence, being something more than mere exegetes of the law. This apogee of jurisprudence occurred especially in the Principate, when the

The archaic law of the Law of the Twelve Tables proved clearly insufficient to address the problems arising from the expansion of the Roman Empire. Alongside sources such as law or the imperial constitutions, the role of jurisprudence in the formation of private law was greater, even than that of law. The creative function of Roman jurisprudence declined when it moved from classical pluralism to imperial monism, reminiscent of contemporary statism.

The greatness of Roman jurisprudence according to Falcón (2010, 86) "...lay precisely in its great mastery of casuistry, in that it was not driven by dogmatic, historical or philosophical interests like modern legal science, not stopping at conceptual and abstract disquisitions, but proceeding inductively, addressing the matter directly, seeking the practical aspect, justice and equity necessary for proper coexistence in society. Roman jurists had an accurate intuition of concepts, far from any theoretical speculation, proper to the constructive task that defines and distinguishes modern jurisprudence. Roman jurisprudence did not have a speculative purpose, but a practical one: to suggest what good action consisted of in the field of Law. It was not so much a matter of writing treatises full of erudition and wisdom, of meditating in order to elaborate systems and doctrines, as of being in contact with life, and of satisfying the needs that it presented. to the world of law." Today, everything is expected from the law; the Romans, on the other hand, expected everything from the wisdom of the iuris prudens. The key to its success was to satisfy the practical needs of daily life, rather than formulating complex systems of abstract concepts.

This is not to say that Roman jurisprudence was not rational. Its authority derived from reason, rather than from experience, unlike common law. Historically, scientific doctrine enjoyed great prestige and even binding force. This is the case of the prudent in Roman law, who gave their name to jurisprudence, understood as

authentic science, as well as that of the glossators and post-glossators in the Middle Ages. In certain historical contexts, such as ancient Roman law, judicial decisions constituted, in some way, sources of law, a law that was, to a large extent, created by the judiciary, through the edicts of the Praetor, edicts that contained the rules according to which its mission should subsequently be carried out. In the Digest, Ulpian defined jurisprudence as iusti atque iniusti scientia; he would be using the term science in a generic sense as equivalent to knowledge and improper. Jurisprudence designated the result of the activity of a special type of men, qualified by their role in public life, which required certain qualities, especially prudentia, which conferred on them moral auctoritas, by virtue of their personality, as auctor, as eminent men. Aristotle dealt with prudence in Book VI of the Nicomachean Ethics. For the Greek philosopher, jurisprudence or prudentia iuris was the application of the virtue of prudence to a specific object: Law.

It is important to note that there are a series of characteristic notes that distinguish Anglo-Saxon precedent from continental jurisprudence, and they are basically the following: For there to be jurisprudence on the continent, it is required that the sentence comes from the hierarchically superior court; Anglo-Saxon precedent can come from any judge or court, regardless of their hierarchical rank (where the precedent would be any previous judicial decision relevant to the resolution of future cases).

From the perspective of the number of rulings required to establish jurisprudence, in Spanish law, the Supreme Court requires several rulings, while in Anglo-Saxon countries, a single ruling is sufficient. In this area, the principle of stare decisis or stare decisis quieta non movere governs, that is, adhering to what has already been decided and not modifying what exists. However, this rule admits exceptions when the previous decision is clearly contrary to reason; and even more so if it is contrary to divine law.

The doctrine of law is as follows: precedents and rules must be followed unless they are clearly absurd or unjust.

There is another meaning of the term jurisprudence: French or Romano-Germanic jurisprudence. It refers to jurisprudence as a judicial phenomenon, as a set of court decisions, or, more accurately, those of specific courts. This is the meaning of jurisprudence that governs Spanish law.

In the opinion of Falcón (2010, 101) "In Spain there is the issue of the horizontal and vertical binding effect of jurisprudence, the horizontal binding effect is the binding of the courts to their own precedents or to the precedents established by other courts of the same hierarchy, while the vertical binding of jurisprudence would be understood as to what extent the jurisprudence of the Supreme Court can be obligatory for the lower courts and what is the extent of the departure of those lower courts with respect to the precedents of the Supreme Court."

In the opinion of Meier (2007, 52) "in the case of Venezuela, the Organic Law of the Supreme Court of Justice of the Bolivarian Republic of Venezuela does not indicate anything about the establishment of the elements that allow us to determine when we are facing a precedent, and even less so, when it is binding or merely deterrent, and therefore, with effects that we could consider normative. Nor does it guide on the requirements for the appropriateness of modifying those criteria that had been previously established, which in a certain way forces the legal operator and, more intensely, the common recipient of the jurisprudential norm, which is the bulk, to become a sort of magician in order to circumvent this lack of precision. In fact, the character of mandatory precedent has even been mechanically or automatically assigned to all judgments issued by the Constitutional Chamber of the Supreme Court of Justice (TSJ), whether or not they contain a binding interpretation, for the sole reason that

A manifestation of the so-called constitutional jurisdiction that, according to this position, transforms its rulings into normative jurisdiction per se. This situation undoubtedly creates a general state of suspicion, a lack of knowledge of what to expect in a matter so sensitive to the democratic functioning of the justice system.

Taking into account the above, Meier (2007, 53) highlights: "The doctrine of the Inter-American system for the promotion and protection of human rights also constitutes, in our latitudes, an obligatory reference for the formation of constitutional precedent, as it is a binding corpus iuris for Venezuela. However, a ruling issued by the Supreme Court of Justice has indicated that when the substantive norms on human rights, contained in international instruments, are incorporated into the constitutional hierarchy, the highest and final interpreter of them for the purposes of domestic law is the Constitutional Chamber, which determines which of these norms prevail in the domestic order and, contrary to all international norms (conventional and customary), it established that the highest and final interpreter of them for the purposes of law is the Constitutional Chamber and that the execution of the judgments of the Inter-American Court of Human Rights should go through the domestic legal system, which could only give it a passivation and proceed with its compliance if the judgment does not violate constitutional principles and norms. This position, with intended vertical effects (especially the justice system), would be inconsistent from the perspective of international human rights law and from the protection mechanisms articulated by the Constitution itself."

In general, according to Ossorio (1981,212) jurisprudence is understood as "...the interpretation of the law made by the courts to apply it to cases submitted to their jurisdiction. It is a central term in the world of law and justice, which refers to the decisions made by the courts and their application in similar cases in a temporal and spatial scope. In other

In other words, jurisprudence is the interpretation and application of law by the courts, which subsequently becomes a rule or precedent for future cases."

Regarding the temporal scope of jurisprudence, Meier (2007, 53) points out that "it refers to the moment in which the court's decision is made and the rule for future cases is established, which would be valid and would operate until it was changed or modified by a new decision." That is, jurisprudence would have a limited duration in time, and would be constantly updated as new judicial decisions were produced. On the other hand, the spatial scope of jurisprudence refers to the territory in which a rule of law established by a court would be applicable; for example, a judicial decision made in a specific country will be applicable only within that geographical area, and not necessarily in other countries. Therefore, jurisprudence would have a territorial limitation that would determine its application in a specific place. Jurisprudence is fundamental to the legal and judicial system, as it allows for the resolution of specific problems and the formation of general principles for practical application. In other words, jurisprudence not only focuses on resolving a specific case, but also has an impact on how the law is interpreted and applied in society.

Furthermore, jurisprudence is a key factor in promoting justice and equality before the law, since through it, clear and equitable legal standards can be established to guide the actions of the parties involved in a judicial process, ensuring consistency and predictability in the legal system. Therefore, jurisprudence is an essential concept in the world of law and the judicial system. Its temporal and spatial scope refers to the application and duration of the rules of law established by the courts in particular cases. Its importance lies in

the promotion of justice and equality before the law, as well as the coherence and predictability of the legal system.

There are several limitations in the temporal and spatial scope of medical malpractice case law, including:

1. Time Limitations: Medical malpractice decisions are based on current medical knowledge and standards, so a decision made several years ago may not be applicable today. Furthermore, laws and regulations can change over time, which may cause previous decisions to be invalidated or re-evaluated.
2. Geographic Limitations: Medical malpractice decisions may vary depending on the country or region where the incident occurred, as medical norms and standards are not always universal. Furthermore, the resources available to enforce regulations and sanction violators may also vary by location.
3. Cultural Limitations: Medical malpractice decisions can be affected by cultural differences and perceptions of medical care. For example, some cultures may have different expectations about pain and suffering, which can influence the assessment of the quality of medical care received.

Jurisprudence in Venezuela refers to the interpretation and application of laws by the courts, especially the Supreme Court of Justice, and is based on the European continental system, which implies that judicial decisions must come from the highest court in the hierarchy.

Unlike the Anglo-Saxon system, where any relevant prior court decision can serve as precedent, in Venezuela a ruling must come from the highest court to be considered jurisprudence. This means that lower courts are

obliged to follow and apply the decisions of the Supreme Court of Justice, since these rulings establish binding criteria for future cases.

Regarding the number of rulings required to constitute jurisprudence, Spanish law requires a greater number of Supreme Court decisions, while in Anglo-Saxon countries a single ruling would suffice. In Venezuela, jurisprudence is built progressively, as the Supreme Court of Justice issues consistent and consistent rulings on a given issue. Jurisprudence in Venezuela plays a fundamental role in the interpretation of laws and the resolution of court cases, constituting a source of law complementary to the law, allowing it to fill regulatory gaps, clarify ambiguous situations, and adapt the legal system to social and cultural changes.

Based on the aforementioned, jurisprudence in Venezuela refers to judicial decisions issued by the Supreme Court of Justice, which has the ultimate authority in matters of interpretation and application of laws. These decisions are binding on all lower courts and are intended to establish unified and consistent criteria for resolving judicial cases.

1.2.-Medical ethics and deontology

From the etymological point of view, Sánchez (1995,112) points out that "the word ethics has its origin in the Greek language éthos, which means custom, later it was translated into Latin as mos and its plural moris, helping us to define the determined attitude towards life, both mean in strictu sensu the same thing, to act according to custom, however, if we analyze its semantic evolution, the Greek word initially meant the place where one lives, to evolve in the time of Aristotle, towards the determination of a more concrete, more intimate place, where one takes refuge

person and also what exists within, the inner attitude; therefore, ethos would come to represent the root or source from which all particular acts emanate. However, for other authors, the noun ethos, in fact, originally meant dwelling, the place where men live, and currently means character, way of being, but, following Aristotle, we find that by a small grammatical modification such as removing the accent, ethos, which is custom, is transformed into ethos, which is character, the way of being of people. For its part, mos, custom, evolved to mean practice, behavior, conduct, but, when the need arose to translate ethos into Latin, it began to be identified as character, way of being."

By deduction, Muñoz (1967,15) states, "the word ethics refers to things related to character, to the way people are, closely related to custom, to theoretical and practical knowledge about behavior, insofar as it is consciously and freely directed toward living and coexisting humanly. For its part, medical ethics studies the moral problems that arise in the professional activity of the doctor, the knowledge, research and applications of advances in science and health."

Frequently, López (2011,52) mentions that "the terms ethics and morals are used ambivalently, with the same meaning, which is incorrect, since morality tends to be particular, due to the concreteness of its objects, while ethics tends to be universal, due to the abstraction of its principles." From a practical point of view, it can be stated that ethics is a science that deals with morality, which concerns human acts, qualifying them as good or bad on condition that they are free, voluntary and conscious, it could also be understood as the fulfillment of duty or the morality of conscience. In the opinion of some authors, our values are basically acquired through indoctrination of the

cultural environment in which we have grown up, generally from an early age, through the influence of social interactions."

Muñoz (1967,34) points out that "Aristotle, Greek philosopher 384 BC stated that in ethics we do not reflect to know what virtue is, but to make ourselves virtuous, because what ethics as a science seeks is to clarify, systematize and base knowledge about morality in order to live more humanly, but always as a guiding contribution to moral praxis, by deduction, ethical knowledge has an influence on our honesty. and integrity, our shape ofthink and the manner ofbehave." For León (2005,23) one of his references was Maimonides, philosopher and master of rabbinic literature, who studied medicine, astronomy and math; two notables doctors Venezuelans unfortunatelyThe deceased Henrique Benaim Pinto and Joel Valencia Parpacen were passionate scholars of Maimonides' works, for their great ethical and moral content. In the opinion of Schmidt (2007,22) "The origin of Bioethics in Venezuela is located in the 80s, focused on the field of Health Sciences, one of its axes being Augusto León Cecchini with his book Medical Ethics, his teaching work at the Central University of Venezuela (UCV), the Venezuelan Medical Federation and as a member of the Academy of Medicine. Likewise, another series of scholars of ethics, medicine and scientific research, who exchanged ideas in gatherings or informal conversations about international news or articles, in which Alfredo Castillo is mentioned,

Isis Nezer de Landaeta and Gabriel D'Empaire at the UCV."

León (1997,34) mentions that "Bioethics in Venezuela arose as part of the desire of some university professors, mostly doctors, interested in the medical-humanist reflection that was taking place in other parts of the world. In 1995, Alfredo Castillo Valery, the first Venezuelan doctor trained in bioethics, together with other collaborators and interested parties, formed a working group within the facilities of the

Experimental School of Nursing of the Central University of Venezuela, which gave rise to the Civil Association National Bioethics Commission (CENABI), composed of Dr. Augusto León Cechini (Honorary President), Dr. Alfredo Castillo Valery (Executive President), Dr. Isis de Landaeta (Vice President), Dr. Gabriel D'Empaire (Secretary), Dr. Óscar Iván Silva (Treasurer), and five members. This commission, since its founding, has been responsible for training talents, especially in clinical bioethics, offering courses, seminars, and conferences taught by both international speakers and Venezuelan medical personnel. It has also performed important work reviewing research projects in the medical field and advising local ethics commissions that have emerged in our country.

In 1995, the first Hospital Bioethics Group or Healthcare Bioethics Committee was established, later established as a Research Bioethics Committee, at the private institution Hospital de Clínicas Caracas. Under the direction of Dr. Gabriel D'Empaire, an intensive care cardiologist with training in bioethics, its functions included reviewing the institution's research protocols, monitoring cases, and promoting training activities. This committee was tasked with reviewing and approving research protocols in their ethical, methodological, and legal aspects, ensuring that they complied with current international standards for biomedical research and with the Venezuelan law on medical practice, ensuring compliance with bioethical principles. To achieve these goals, the committee established internal regulations, which established the working and operating rules for decision-making in complex cases, and provided instructions for medical researchers. He also created formats for obtaining the necessary requirements to submit a protocol for the committee's consideration. However, due to the

Due to the lack of awareness among the medical profession about this discipline, reactions and difficulties soon appeared, with the committee being perceived as an entity that hindered freedom of research. Furthermore, the lack of trained people in the area and the lack of bioethics legislation in our country, toward further difficult the assessment of the cases.The creation of this committee is considered a successful experience in the organization of a bioethics committee - even though at the time of its creation it was not clear how it should function - which has a wide range of functions, including: teaching function, with programs aimed at training talents; advisory function, with the analysis and deliberation of specific research cases; and informative function, with the dissemination of knowledge and experience of the committee's activities.

León (1997,40) emphasizes, pointing out that “the process of expanding bioethics in our country corresponds to the different efforts that over the years have been laying the foundations of the bioethical paradigm. This process has been characterized by concrete actions that account for new institutional forms to develop the discipline.” For Cubero-Castillo (2015,3) “the creation of legal regulations that are based on an important event in our country, such as the Constitutional Reform of 1999, the modification of the Science and Technology Law of 2001, the new perspective introduced in the Bioethics and Biosafety Code of FONACIT, among others.”

In the opinion of León (1997,19) "...our Central University of Venezuela (UCV) has also been the setting for the proliferation of different commissions that operate separately; many respond to particular interests, in accordance with the guidelines and activities of the institutes and schools that comprise them. The University Clinical Hospital, the Institute of Biomedicine, the Rafael Rangel Hygiene Institute, the Faculty of Dentistry, and the Faculty of Sciences are some of the bodies that operate separately.

universities where there is a bioethics committee. With the support and experience of CENABI, the first Master's in Bioethics in our country is launched, specifically to promote clinical bioethics and the study of ethical issues arising from the development of biomedical technology. Among the topics covered are those related to the beginning and end of human life and quality of life, promoting the ethics of biomedical research.

Some authors infer that bioethics in Venezuela is still in a stage of assimilation, from which it is necessary to advance in order to overcome the bifurcation originated from the birth of the bioethical paradigm and reorient the reflection towards a global bioethics, capable of understanding man as part of a system planetary complex. He process ofInstitutionalization has had a slow and circumscribed character, not articulated to a capacity building program in the area, because the few action centers created did not maintain structure and the efforts made were individuals and fragmentary.

León (1986, 29) argues that "the constitution and direction of bioethics committees in Venezuela have been the product of private interests, superimposing private over public space in the management and administration of research; and the institutionalization process that has been carried out to date remains anchored in foreign epistemological assumptions, disjointed from current public research policies."

Thus, it is necessary to open new spaces for training and research in bioethics, in order to reflect on the impact of science and technology from our historical and cultural perspectives, transcending from the practical (bioethics committees) and normative (bioethics codes) perspective to a contextualized epistemological dimension.

so that it becomes a true biopolitical force that makes possible the establishment and control of effective research policies that help solve our country's urgent problems.

In the opinion of León (1995, 15), "The constant emergence of various ethical dilemmas arising from the advancement of scientific knowledge often exceeds the capacity of the medical professional to provide the correct solutions and develop new standards of moral action. León (1981, 22) also points out that "Dr. Luis Razetti intensely criticized the moral deviations of doctors, using the expression medical industrialism," all of which are recorded in the current era, only magnified by the intervention of numerous factors associated with the progress of medical technology. Current ethical dilemmas are numerous and increasingly complex, and their social importance is increasing with unusual rapidity, since new medical knowledge constitutes a tremendous impact, not only on the medical profession, but on the community as a whole, due to its social, economic, and political repercussions. Although today the essence of the practice seems to be the same, the same is not true of the way problems are addressed."

The modern physician, individually, is not competent—without help from outside his profession—to obtain satisfactory solutions to the diversity of new ethical situations." The simplicity of the problems, even in recent times, facilitated access to the correct solutions; however, today, the tremendous difficulties derived from scientific and technological progress force us to allow, even more, to request foreign interventions in the medical territory so jealously guarded while exhibiting the self-sufficiency required to achieve satisfactory solutions. León (1993,11) explains in his work that "at the undergraduate level, free discussion is carried out by students, with the advice of the

respective preceptors, of concrete situations, avoiding abstract approaches, confronting students with the ethical dilemmas associated with the practice of the medical profession, after providing the information required for the analysis of the different moral perspectives."

Noting in this regard, "Medical training programs in the initial stage are aimed at elucidating situations rather than demanding specific answers, subsequently, at the postgraduate level, the coordinator should maintain close ties with the undergraduate coordinators, thus facilitating the continuity of the program. At this stage, seminars will be held periodically, but they will complement—and not replace—the ongoing discussion of individual situations that arise in the daily practice of the respective specialties. At the third or continuing education level, the collaboration of scientific societies and medical associations is required. Consideration of ethical issues arising from general professional practice and the practice of the various specialties should always be formally included in annual professional and scientific meetings: forums, symposia, seminars, roundtables."

In the opinion of Sánchez (1995,13) supported in turn by the opinion of the Spanish philosopher and theologian Xavier Zubirí (1898-1983), disciple of Ortega y Gasset, "...ethos is a way or mode of life, while for the Greek sophist philosophers of the 5th century it consisted of being a good citizen, being successful as such, adapting to local customs and knowledge, for his part Socrates, (470 - 399) BC, Plato's teacher, would raise the capital philosophical problems of ethics, putting philosophy at the service of custom and establishing that supreme wisdom is reached when one is able to clearly distinguish good from evil. Morality relates exclusively to voluntary and free human acts, but not to the acts of men,

"The former are the product of reflection, of the dominion of the will, and the latter may not be, as is the case of actions carried out by forces outside the will, which is why one cannot speak of the morality of the acts of children, of the insane, among others."

On the other hand, Peiró (1994,29) states that "medical deontology etymologically comes from the Greek words deontos (duty) and logos (speech or treatment), so it could be defined as "treatise or science of medical duty or medical obligations, serves as a moral rule to which the actions of the doctor are subject, which must be known by him. The possession of a medical degree does not imply knowledge of the science, but it is only presumed; on the other hand, a straight moral conscience is not always possessed and when it is, it does not necessarily have to be equipped with the moral and intellectual instruments that allow one to take the acquired knowledge to its ultimate consequences, within the strictest moral principles."

Professional deontology addresses duties and obligations by formulating a series of standards applicable to all those who practice a particular profession. Although its usefulness could be questioned, since ethics and deontology are interchangeable concepts, they complement each other. While deontology is responsible for developing standards and demanding behavior, without the perspective of ethics, which drives motivations, it would remain without a point of reference, as the meaning, the reason for its essence, would be lacking.

Muñoz (1967,34) understands that "Deontological Codes reflect the general duties of the profession, as well as those towards its clients, colleagues and the society to which they belong." The codification process is open, since it arises from the historical decantation of principles and customs, the result of the reflection of professionals and the adaptation of behaviors to the evolution of the profession and social reality. Then, it results

It is logical to think that ethics and deontology are absolutely necessary from any point of knowledge that analyzes them for the good performance of a doctor.

1.2.1.-Historical background.

Around 1770 BC, Hammurabi, king of Babylon, an ancient city in Lower Mesopotamia, issued a code of laws and regulations to regulate the conduct of his subjects, including a large number of legal precepts relating to medical practice. Curiously, these do not speak of morality or immorality, but rather of the potential negative effects of an intervention, after which, without further discussion, a penalty was imposed. For Sánchez (1995, 86), "The Code of Hammurabi established clear rules for the practice of medicine, to the point of stating: 'If a doctor causes a serious wound to a patient with an operating knife and kills him, that doctor's hands must be cut off.'" In Egypt and Greece, there were secret medical colleges where rules on the art of healing were stipulated and regulations were structured that were characterized by the severity of the sanctions, even the death penalty.

According to Assyrian clay tablets, physicians of that time never accepted the care of the terminally ill. As for the severe corporal punishments specified in the Code of Hammurabi for medical errors, however extraordinary they may seem to us, they were in line with those established for other professions or for personal offenses against others.

When studying medical practice in China, López (2011,43) observes that "initially this was carried out by humanism, without any economic or social incentives in return, being exercised by rulers, wise men, nobles and priests, medical knowledge was considered a secret power and could only be transmitted to children or people who were highly qualified socially and morally."

The medical act, by its very essence, is an ethical act, according to López (2011,45) "but the problems it raises and its foundations will vary in relation to the historical moment, religious beliefs and social conventions. The physician in his healing work must be guided by two principles, love for man and love for his art, is responsible for fulfilling his duties to the patient, his colleagues and society. " In this regard, we consider it important to mention Hippocrates of Cos (460-370 BC) who was born on the Ionian Island of Cos, son of Heraclides and Minarets, learned the art of healing with his father and with Herodicus and although history has even come to question the existence of Hippocrates, references from Plato and Aristotle assert that he not only lived, but was the most outstanding physician of his time. Thus, the Hippocratic Oath encompasses invocation, commitment to the code, ethical matters, surgery, integrity, professional secrecy, and within its philanthropy, we find the equal treatment of care regardless of nationality, status, or wealth. The consolation of the sick as an adjunct to medical treatment, free charitable assistance to the poor, and the moral and therapeutic appreciation of living with pain are considerations contained in the Deontological Code of Venezuelan Medicine.

During the Renaissance period, all types of medical practice that did not pass through the filter of university teaching were repudiated. On the other hand, epidemics of gallic disease or syphilis, considered a recrudescence of syphilis, forced doctors to think that not everything was in the knowledge of the ancients, but that nature hid secrets that would become evident at different times, and led them to propose a possible degeneration in humanity, making it susceptible to suffering new and terrible evils. As a result, the contribution of personal experiences of doctors was added to knowledge, it was concluded that if certainly, the medical art included everything in its general premises, it should also be enriched by scientific knowledge.

individual. During the Renaissance period, Rivero (2009,52) notes, “a good percentage of the social reputation of a good doctor was closely related to the type of clientele he had and his way of handling the collection of fees, having to be cautious and precise in how much and when to charge, being able to temporize the collection in chronic illnesses, but not in acute illnesses or those with a possible rapid outcome. This criterion was modified with the passage of time, the innovation of technologies and the emergence of new medical specialties.”

Likewise, in ancient times the quasi-sacred nature of medicine was symbolically implicit during the first approach of the doctor to his patient, where he was clothed with a priestly formality and his appearance was to remind the patient of the image of Jesus Christ, who had the gift of healing; the doctor had to be benign, merciful and charitable, going so far as not to charge poor patients, a practice that - in some cases - has been maintained over the years.

In Cortina's opinion (1996,55), he maintains that "in general terms, it is accepted that the doctors who make the most mistakes are the newest ones, those who have recently graduated, or those who are in their first years of training"; it is also known that performing autopsies and clinical anatomy meetings allow for the recognition of errors through continuous learning, as well as understanding medical errors, their control, and the behavior and variation of diseases. According to the Autonomous University of Mexico, in the Faculty of Medicine (1977,39), "...when a doctor compares his nosological diagnoses with postmortem pathological reports, he acquires a good idea of his own skills and limitations as a clinician. This is the function of the clinical anatomy session, which contributes to the doctor's continuous learning and allows him to constantly improve his professional practice."

According to Burton (2007,1478) "There is scientific evidence that one of the factors linked to errors is the age of the patient, occurring more frequently in the extreme ages of life, that is, children and the elderly, as well as in complex surgical procedures."

The vast majority of medical errors involve the performance of the physician, the team accompanying him or her, and other factors, such as rest, so much so that it has been determined that sleep deprivation for physicians during continuous on-call shifts increases the possibility of serious errors after the 24-hour shift is exceeded. According to Lockley (2007,15), "...the lack of adequate rest affects the psychomotor performance of a professional, similar to an individual who has consumed alcohol. Likewise, another risk factor for committing errors is poor communication between doctor and patient, when the latter falsifies information provided in the medical history during the care process. However, traditional techniques of history taking and physical examination continue to be fundamental in controlling diagnostic errors."

It is important to emphasize that all medical specialties are susceptible to errors. However, those where diagnostic uncertainty is greatest and where a delay or mistake can lead to malpractice are: surgery, emergency medicine, intensive care, anesthesiology, and internal medicine. During medical practice, errors in the prescription of a particular drug also frequently occur. This is part of the medical act and involves the prescribing physician and other professionals. Errors occurring in this chain are potentially harmful to the patient, either due to the harm they can cause by administering or not the appropriate medication, the toxic effects generated by these drugs, the lack of the expected benefit, and the economic cost to the patient.

1.2.2.-Bioethical principles and voluntary informed consent

In this section, we will begin our study of bioethical principles by addressing autonomy, understood as self-governance; a concept first used to refer to the capacity of independent Greek city-states to govern themselves. According to Beauchamp (2002, 98), "an autonomous individual is one who acts freely according to a self-chosen plan and, to exercise it, requires both freedom and determination, that is, the capacity for intentional action, a concept that does not admit of degrees."

On the other hand, some philosophers consider that non-maleficence and beneficence are part of the same principle, while for other authors the obligation not to harm is a prohibition, just as not to steal, not to hurt, not to kill, and is clearly distinct from the obligation to help others. Non-maleficence consists of not causing harm, an absence of action, while beneficence prevents it, seeking the good. In everyday language, the latter refers to acts of goodwill, kindness, charity, altruism, love, and humanity. When Beauchamp and Childress (2002, p. 100) point out this principle, they are referring to "those acts that are an ethical requirement in the field of medicine since, according to these authors, before treating a patient, we are obliged to perform a risk-benefit assessment."

The principle of justice considers that inequalities in access to health care and the increase in costs have caused a debate in the health field about whether social justice would apply in these cases the classic maxim of Ulpian iustitia est constans et perpetua voluntas ius suum cuique tribuendi. In such a way that injustice occurs when an individual is denied the good to which he or she has the right or the burdens are not distributed equitably. Another relevant aspect in the opinion of Daniels (1985, 241) would be that of distributive justice, referring to "the impartial, equitable and

appropriate in society, determined by justified norms that structureThe terms of social cooperation, its aspects include policies that assign various benefits and burdens such as property, resources, privileges and opportunities to various public and private institutions, including the government and the health system."

The problems of distributive justice mentioned above increase under conditions of scarcity and competition, however, several distribution criteria have been proposed, to each person according to: a) equal participation, b) their individual needs, c) individual efforts, d) social contribution and e) merits.

In this author's opinion, there would be a conflict of interest between those who require health services and those who bear their costs. Equality of opportunity for all members of society must be protected. These services must be reformed if they are unable to guarantee this, since equality is enhanced by homogeneity in access to health care for all citizens.

Medical paternalism is understood as the vertical doctor-patient relationship that emulates that of a father and son, where the doctor replaces the former and the patient the latter, with the consequent impairment of the freedom, autonomy, decision-making power and wishes of the patient, supported by the principle of beneficence. It can cause harmful effects such as the concealment of information, under the assumption that the doctor knows what is best for the patient.

It is generally accepted that bioethical principles originated during the Second World War, leading to the creation of the Nuremberg Code and the Universal Declaration of Human Rights. Although some authors consider these principles to be imperfect obligations of moral coercion, it is often evident that their disrespect causes repercussions in the sphere of civil and criminal law. All of this is

closely related to the right to information, which is part of the lex artis ad hoc in medical practice and constitutes a right of the patient, since in order to be able to decide freely, fully and autonomously, it must be explained to him in a complete and adequate manner, truthful, timely, complete, adequate and intelligible to the cultural level, being the duty of both the doctor and the nursing staff to collaborate in ensuring that it has been captured in its entirety.

Currently, the trend is for the patient to abandon medical paternalism and be able to emancipate themselves by knowing both their illness and their rights, among them, as required by the Law on the Practice of Medicine (2011,5) "...to demand a high degree of professionalism and training from the staff that assists them, to be treated with respect and cordiality, fair fees, appropriate to the fair price and the level of complexity of the treatment", freedom that allows them to refuse to undergo treatment as long as they are mentally competent, since in cases of mentally ill people their relatives, guardians or curators will decide, and also to protect their confidentiality or medical secret, which in most cases is absolute but in certain occasions may be relative and be revealed when it is a legal mandate, a vital event such as a birth or death, a disease of mandatory or epidemic reporting, to avoid the conviction of an innocent person or to keep a guilty person free, and when it is the patient themselves or the parents of the minor who authorize its disclosure. In addition to patient empowerment, the physician will always strive to ensure that the benefits far outweigh the potential risks and complications. If he or she feels inadequately trained, he or she should humbly acknowledge this limitation and refer the case to a more qualified colleague or ask for assistance in carrying it out.

Since medicine is an inexact science, every possible attempt must be made to minimize the possibility of failures, so that they do not occur.

trigger malpractice, monitoring any irregularities in laboratory tests, imaging studies in order to correct them in time, also making use of the tools that safeguard the responsibility of the doctor and that guarantee freedom and respect for the autonomy of the patient, such as, in the opinion of Schmidt (2013,14) "voluntary informed consent .." an instrument normally written, which contains the manifestation of the will of the patient free of all coercion, who after having been sufficiently informed of the risks and complications of a procedure, states to adhere to it, includes identifying data, the procedure to be used, the signature and at the bottom a space for revocation in case the patient so decides, however, this document can be invalidated or challenged if it is shown that the legal extremes were not met and there are also exceptions when it comes to saving the life of the patient, in cases of epidemics or in the so-called state of therapeutic necessity or therapeutic privilege.

In the opinion of Cubellum (2004,25) therapeutic privilege occurs when “objective reasons show that the patient's knowledge of his situation could seriously harm his health.”

In the opinion of Galán (1997,35) “Voluntary informed consent is closely linked to the right to information and is one of the elements that make up the lex artis ad hoc in the practice of medicine and a prerequisite for any procedure.” In this sense, in the opinion of González (2000,96) Spanish criminal law doctrine establishes that “when the absence of voluntary consent or defects in it are observed, whether due to incomplete, biased or partial information, the criminal liability will be of the doctor for the crime of injury or reckless homicide when an unsuccessful result occurs and will give rise to charges for the crime of coercion.

Voluntary informed consent, according to Schmidt (2013,3) is considered "a basic pillar in the doctor-patient relationship and in the rights of patients in modern medical care, this process is based on a series of requirements, which include information on the treatment to be administered to the patient, knowledge of the risks, benefits and available alternatives, as well as understanding and the ability to decide autonomously." However, in some environments, voluntary informed consent may be conditioned by multiple factors, especially in social situations where freedoms are compromised, the lack of respect for basic human rights and the existence of repression.

In these settings, patients often lack adequate information about their treatment, the potential risks, and available alternatives, and their decisions may be influenced by authority figures or medical personnel. Furthermore, in these contexts, patients may fear retaliation if they refuse to follow guidelines or accept proposed treatments, which can significantly limit their ability to make independent decisions.

Another important restriction on voluntary informed consent is the effect of external authoritarianism, such as the presence of authoritarian family members, friends, or caregivers who can influence the patient's decision. Patients may be persuaded to make decisions that do not represent their true wishes and preferences, which can lead to negative health outcomes. Furthermore, those under legal guardianship or who lack the capacity to make decisions for themselves due to their age or mental condition may be especially vulnerable, as their decisions may be subordinated by those in positions of power in their lives.

It is important to emphasize that informed voluntary patient consent is one of the most fundamental rights in any medical setting. It is essential that governments and medical authorities institute measures to guarantee its protection and promotion at all times, even in the most difficult and hostile contexts. It is vital to ensure patient autonomy and informed decision-making that is aligned with their true wishes and medical needs.

Among the range of factors that may affect the patient's consent, we mention the following:

1. Social: The influence of family and friends, education level, socioeconomic status, and the ability to make independent decisions can also influence consent.

2. Governmental: Legal requirements and regulations in each country often limit patient options. For example, there may be policies that require patients to receive a certain treatment or restrict their choice of treatment through a specific healthcare provider.

3. Cultural: A patient's culture may affect their perception of informed consent; for example, certain cultures may give more weight to the opinions of family or community rather than to individual decisions.

4. Economic: Lack of financial resources can limit access to the information and medical care needed to make informed decisions. On the other hand, the financial influence of pharmaceutical and medical device companies can affect patient decisions.

5. Educational: The patient's level of education and ability to understand medical information affect their decision-making ability.

Voluntary informed patient consent can vary from nation to nation due to differences in healthcare systems, laws, and cultures. For example, in some countries, the healthcare system may be more patient-oriented, with an emphasis on decision-making and shared responsibility for healthcare. In these cases, informed consent is likely to be more detailed, with comprehensive information about the risks and benefits of a treatment and possible alternatives. However, in other countries, where the healthcare system may be more physician-oriented or where there are fewer resources for healthcare, informed consent may be less detailed, and full treatment choice may not be possible. Furthermore, the law may differ between countries regarding what is considered valid consent and what information must be provided to the patient. In some countries, written consent may be required by law, while in others, a verbal conversation may be sufficient. In some countries, patient autonomy and shared decision-making may be highly valued, while in others, there may be greater reliance on medical authority and delegation of decisions. Although voluntary informed patient consent is a globally accepted practice in healthcare, it can vary from nation to nation due to differences in healthcare systems, laws, and cultures.

Exceptions to the request for informed consent in competent patients are considered: Those situations where the patient gives his autonomy in decision-making to the doctor or third parties, due to the complexity of the

problem, or because the patient has absolute confidence in his or her physician, expressing: "do what you think is best," however, the physician should not rush to act on such a request, but should inform the patient of the treatment options and suggest that he or she make his or her own decisions; however, if the patient persists in his or her attitude, the physician must always look out for the patient's best interests. Another circumstance that may arise is when the provision of information could be harmful to the patient; in such circumstances the concept of therapeutic privilege is invoked, allowing the physician to withhold information that would likely cause serious physical, psychological, or emotional harm to the patient, as would be the case in cases where there is a high probability of suicide if the diagnosis implies a terminal illness. It is important to highlight the danger of abusing therapeutic privilege, which is why it should be used only in extreme circumstances, ensuring that all patients can bear the facts and consequences of their illness, showing sensitivity to cultural and personal factors when communicating bad news, especially that of imminent death, remembering that the doctor is not obliged to offer the patient a useless or benefitless treatment.

The recognition of the provision of information marks a qualitative leap from the paternalistic practice of medicine; ultimately, it consolidates respect for human dignity. It is important to distinguish between therapeutic information and information that is essential for adherence to the prescribed treatment, providing the latter with knowledge of the various options available to them. Raising awareness about the value of information, treatment options, and freedom of choice are part of the guiding principle for avoiding medical malpractice.

1.2.3.-Medical ethics and social conditions

According to Lain (2004,101) it would be terrifying to think that there have been societies in which a newborn with a physical defect was taken away

Life, this is how in ancient Sparta, when newborns were not healthy enough, they were abandoned on Mount Taygetus. In fact, Sparta practiced eugenics, since at birth the Spartan child was examined by a commission of elders in the portico, to determine if he was beautiful and well formed, otherwise he was considered a useless mouth and a burden on the city, consequently, he was taken to Apóthetas, a place of abandonment at the foot of Mount Taygetus, where they were thrown down a ravine. Ethical values change over time and space, for each society and for each moment there have been differences, when someone believes they have the absolute truth, then problems arise.

The

Various moral criteria around the world have emerged as a result of different agreements. To understand this in depth, we mention a literary work that clearly illustrates this: The Cider House Rules by the American writer John Irving, a bestseller in 1999, whose script was adapted for a film version and won an Oscar. Irving (2000, 76) tells "the story of an elderly doctor who was in charge of a rural orphanage where women came to give birth and abandoned their babies, since they were the product of unwanted pregnancies. At the same time, the doctor treated women who wanted abortions. Over time, an orphan who was never adopted became the doctor's assistant and learned what the old master taught him about medicine empirically. However, he refused to perform abortions; he would only assist in births and collaborate with the rest of the orphanage's care." Later, this young orphan would abandon the hard life of the orphanage to work as an apple picker in an orchard, where he is forced to help abort a teenager raped by her own father. It is then, at that very moment, that he understands that the rules written by society have been drawn up by people who have not experienced the true nature of life firsthand.

conflict of what an unwanted pregnancy implies and would return to the orphanage to replace his old teacher performing births and abortions.

On another note, we must mention that around the 1940s -1950 in the United States experiments were allegedly carried out on human beings whose population consisted of indigenous people, prisoners, the mentally ill and children, the research consisted of injecting 4 syringes containing pathological material in order to test the clinical evolution and therapeutic response in sexually transmitted diseases (syphilis, gonorrhea and others) causing a litigation for 83 deceased people, as well as sick, blind survivors, and with joint problems, those involved would allegedly have been the Rockefeller Center, Bristol Laboratories and Pfizer who denied responsibility claiming that they were testing drugs as a treatment.

There are historical situations in the evolution of the world where the practice of medicine has been placed in a dilemma of tension between Human Rights and professional ethics, within a context of institutional, administrative, and other threats, as well as other demands of the social moment in which medicine is developed. In such circumstances, ethical and professional principles may be violated, as the physician will find his or her freedom of action impeded, violating his or her free will, decisions, and criteria. Considering that for the adjudication of medical liability, the rule is established to determine whether the action is performed freely, allowing for the possibility of carrying out a practice in accordance with ethical and professional standards.

In some extreme situations, medical decisions would be co-opted, either because the doctor is forced to go to great lengths in treatment and care to assist a wounded homicide victim, or on the contrary, he is prevented from providing assistance to a patient who is a political persecutor, a war fugitive or a dissident, then there would be an omission of the duty to provide assistance and a denial of

help, since the solidarity, humanism, laws and respect for Human Rights that characterize this profession would be compromised.

Human rights are closely linked to the rights of patients, their health, privacy, and individual freedom. The World Medical Association (WMA, 2015, 12) and other international codes emphasize the importance of "scientific and humane care without discrimination, the receipt of adequate, understandable, and truthful information, self-determination, respect for the confidentiality and privacy of their data, and cultural and moral convictions."

The obligations and duties of physicians are contained in the codes and moral laws of the art of medicine, while others derive from current legal requirements given the evolution of society. These include professional secrecy, providing adequate information to the patient, respecting voluntary informed consent, the obligation of knowledge, diligence and technique on the part of the physician, continuity in treatment, care and advice, certification of illness as well as birth and death.

Each and every agent involved in the medical act is individually responsible for the totality of the damage caused. It is within the power of the judge to attribute or exempt each of the health agents to a greater or lesser degree and to establish the percentage of responsibility for the harmful event.

Eventually, a doctor who acts against a patient's wishes, even to save his or her life, could face legal action due to the principle of autonomy, which is nothing more than the moral right to self-governance. This can lead to professional and, naturally, ethical conflicts.

1.2.4.-Importance of the study of ethics in medicine

There are those who hold statements such as that ethics is learned in the family, not in medical school, or that it is learned by observing the performance of older doctors and not in books, magazines, or conferences. This is important because these are often reasons for not dedicating enough teaching hours to it in medical schools, even though its study prepares future doctors to recognize difficult situations and treat them rationally and with principles. Currently, medical ethics has been greatly influenced by Human Rights, and doctors often have to deal with medical problems. derived from violations of these.

Medical ethics is related to law, there are laws that specify the conduct and approach to ethical problems in patient care, in addition, the regulatory authorities that grant licenses in each country can punish physicians for violations of these codes. Generally, ethics prescribes higher standards of conduct than those of the law, requiring the physician to disobey unethical demands. In addition, understanding that laws evolve over time and from one country to another, ethics is applicable in all nations of the world, and includes compassion, competence and autonomy. The former is related to understanding and concern for another person's affliction, the physician must identify the patient's problems and their causes, relieving them, evidence that patients respond better to treatment if they perceive that their physician appreciates their concerns and treats them rather than their illness. On the other hand, medical incompetence could lead to death or serious illness for the patient, therefore, doctors need a long period of training, and taking into account the rapid progress of science, it will be a great challenge to stay

updated, because new situations and ethical problems arise due to changes in medical practice, the social and political environment.

Autonomy, understood as self-determination, is another cornerstone of medicine. It has evolved greatly over time. Physicians have accepted and respected it, but it often conflicts with medical paternalism.

1.2.5.-Teaching models in medical bioethics

According to Brussino (2002,22), political and economic changes entail a certain vision of the world and of society, while crystallizing certain ideas about right and wrong, for that reason, they also promote certain values or, on the contrary, counter-values; the first challenge to recover the humanization of the doctor-patient relationship is to adequately educate medical students in bioethics in times of transition from a solid, stable, repetitive modernity to a flexible, fickle one, where social structures no longer endure over time and are often not useful as reference models in the field of research ethics, where practically all the terms included in international standards have been questioned, such that they have less and less moral weight. These can be discovered in the debates on exploitation, vulnerability, undue inducement, compensations and conflict of interest, among others.

The task of educating in bioethics begins in a first stage by discovering those values and continues in a process that has different moments that include: a) Learning to discover values, those that we carry within us, whether we know it or not, and others that we consider adequate and appropriate for all human beings, without them being imposed on us, which is learning to think for ourselves. It is important to apply those values to the decisions we make and that we want others to take into account b) We must understand that making decisions implies

take responsibility for doing so and be able to justify it morally, but also have the courage to defend the values we have identified in that decision and in which we believe and trust.

It has been suggested that certain skills are necessary to cultivate humanism in today's world, and it has been proposed that the first skill in higher education should be a critical self-examination of oneself and one's own cultural, moral, and educational traditions.

In the opinion of Brussino (2002,25) for the teaching of bioethics in medicine "a model has been used in which the student assumes a passive role, he only listens and absorbs, which is why it has also been called the banking model, due to its reference to the deposit of knowledge in someone who is considered a priori empty, and the educator model, which promotes critical reflection and one's own argumentation, from the reasons that he considers adequate or from others that the student is able to search for himself, understand and assimilate." In this approach, the inquiry and confrontation of evidence and reasons becomes fundamental as a first step towards understanding and critical reflection on the problems.

For years, initiatives such as the so-called Socratic approach to education have existed, with its variations depending on the era and context. Since the 17th century, various thinkers began to question educational models based on memorization and obedience and proposed greater student participation in the learning process. This gave rise to the so-called Socratic approach, strongly oriented toward changing attitudes through the educational process and clearly different from the so-called pedagogical approach based on traditional educational methods.

In Latin America, the problematization model had an important development through the education program promoted by Paulo Freire in the mass literacy campaigns in Brazil. In this proposal, education is understood as a tool for the construction of a

A critical subject of social transformation, recovering the values of one's own culture as problematizing elements of reality, from which the educational program is constructed. Learning, therefore, is a factor in changing attitudes and practices toward a process of social transformation.

Those in power establish educational content and models that aim to legitimize and perpetuate the power structures that sustain them through a true liberalization of the education market. A good example of this is the direct or indirect influence the pharmaceutical industry has on medical programs in some countries.

The task of the bioethics educator, within the problematizing education model, would be to accompany the dialogic process in the classroom: to question, reflect, and challenge each medical topic during class time, emphasizing the ethical and human aspects, values, and the legal framework. They would also propose norms for democratic dialogue and exercise them constantly, establishing with students, in each subject of the medical program, paths to identify values. This model proposes research to obtain new knowledge, using research methods and sources to find the most fair and ethically appropriate solution for each specific case. They would also provide ethical input, emphasizing its importance and impact on the different areas of theoretical medical knowledge, through classes, forums, and interventions. While promoting debate on the prioritization of real patient problems, promoting possible solutions, and assessing the ability to argue and justify different alternatives in resolving medical problems involving life-and-death issues in different medical subjects, as well as weighing the risks and benefits of different treatment options for patients. This model was applied in an experiment carried out with the Network of Bioethics Committees.

At the Ministry of Health in Córdoba, Argentina, for over 10 years, it has also been applied in another more recent experience, in the UNESCO Permanent Education Program in Bioethics, using the virtual distance learning modality with good results. (Cortina, 1996, 27)

1.2.6.-Public ethics and private ethics in medical malpractice

Public ethics is synonymous with justice, which has been its traditional name since Plato and Aristotle. It is the morality that aims to be incorporated into positive law, guiding its ends and objectives as just law, when it has not yet been incorporated into positive law. It serves as a criterion for judging the latter and as a program for achieving power. We call it critical morality. Once it is incorporated into positive law, it is called legalized or positivized morality. In contrast, private ethics is an ethics of content and conduct that outlines criteria for salvation, virtue, goodness, and happiness; that is, it guides our life plans; it is precisely the direct channel for humanization. It can be religious or secular, and its goal is moral autonomy or independence. It has two dimensions: individual and social. The individual's objective is to regulate our conduct toward its ultimate end, while the second does so through our social relationships with other people.

Public ethics and private ethics are distinguished, but they communicate. One of the great errors of critics of modernity is the confusion between public ethics and private ethics, both converting private ethics into public ethics, and considering that public ethics can become private. (Garzón and Vázquez, 2004, 56)

Public ethics and private ethics are related in medical malpractice, as both involve ethical decision-making processes and are therefore linked to the responsibilities of health professionals. Public ethics in medical malpractice refers

The standards of conduct and values that are accepted by society and the health system as a whole. These public ethical standards are reflected in laws and regulations, codes of professional ethics, and organizational policies and procedures.

On the other hand, private ethics in medical malpractice refers to the personal, individual moral code of each healthcare professional, which influences their individual decisions and actions in patient care. Private ethics can involve considerations such as honesty, compassion, and integrity, which are not necessarily required by public ethical standards.

In cases of medical malpractice, both public and private ethics play an important role in determining fault and liability. Ideally, health professionals should adhere to both the public ethical standards outlined by the system where they practice and the personal ethical standards to which they are bound. Failure to do so could have legal and ethical consequences, as well as damage the reputation and credibility of the health professional, their colleagues, the institution where they operate, and the health system as a whole. Overall, public and private ethics reinforce each other and complement each other to ensure that health professionals provide safe, effective, and ethical care to their patients.

1.2.7.-Ethical decisions in medical practice

Ethics is pluralistic, people have disagreements between what is right or wrong for various reasons, in some societies, this diversity of criteria is considered normal and there is great freedom of decision, as long as the rights of others are respected, but in other more traditional cultures there is greater agreement on ethics and there is greater social pressure, often backed by laws to behave in a certain way.

way, religion can also play a determining role in ethical conduct.

Deciding what is ethical or unethical will vary depending on the society. In liberal societies, individuals will have a great deal of freedom to decide for themselves what is ethical, although they will likely be influenced by family, friends, beliefs, the media, and other external factors. In more conservative cultures, family, clan elders, religious authorities, and political leaders generally play an important role in determining this.

Despite the differences noted above, it appears that most human beings agree on certain fundamental ethical principles, specifically the basic human rights proclaimed by the United Nations Universal Declaration of Human Rights and other widely accepted and officially approved documents. These rights are most relevant: life; non-discrimination; freedom from cruel, torture, or degrading treatment; freedom of opinion and expression; and equal access to public services and healthcare.

For centuries, the medical profession has developed its own standards of conduct, expressed in codes of ethics and related policies. At the global level, the World Medical Association (WMA, 2015, 32), whose ethical statements reflect the 75% consensus vote in favor of adopting any new policy, has developed a wide range of guidelines specifying the behavior that physicians should exhibit regardless of where they live or work. These standards may have the force of law, depending on the country's understanding of medical law. The ethical guidelines of medical associations are general and cannot address every situation that may be encountered. In most cases, the physician must decide for himself the correct course of action. However, in making that decision, it is useful to know what other physicians would do in similar situations.

We observe that medical ethics can change over time, in response to technological advances, the civilization of people, the values of society, and the culture of the country. An example of this is euthanasia, where there is a wide difference of opinion among international medical associations: some condemn it, others are neutral, and at least one, the Dutch Medical Association, accepts it under certain conditions. Similarly, regarding access to medical care, some associations support equality for all citizens, while others tolerate great inequalities. Doctors in some countries trust that their governments will not force them to engage in unethical behavior, while in other countries, they may find it difficult to fulfill their ethical obligations, for example, maintaining patient confidentiality in the face of demands from the military or police.

Physicians and medical students will not be ethically bound by simply following the recommendations of the WMA or other medical organizations, as these provisions are general, and the individual needs to determine whether or not they are applicable to the particular situation at hand. Furthermore, many ethical issues arise during medical practice, for which there is no express guidance from medical associations. Therefore, physicians are responsible for their own ethical decisions and their implementation. However, there are different ways of addressing ethical issues, and in general, we could divide them into two categories: rational and non-rational. It is important to emphasize that the latter does not mean irrational, but simply distinguishes them from the reflective and systematic use of reason in decision-making.

The rational approach would include deontology, consequentialism, principlism and virtue ethics, deontology involves the search for well-founded rules that can serve as a basis for making moral decisions, an example of this rule would be treating all individuals equally,

Its foundation could be religious, for example, the belief that all human beings are equal before God. Thus, once rules are established, they must be applied to specific situations, and this is where disagreement often arises about what the rule requires, such as not killing another human being would prohibit abortion.

Deontology and consequentialism are two characteristic types of ethical theories, the expression "consequentialism" translates the English word "consequentialism", consequentialism must be distinguished as a feature of utilitarianism, so that the latter can be broken down into three elements: "welfarism", or interest in individual well-being to define utility; "sum ranking", consisting of evaluating by the sum of individual utility; and finally, "consequentialism" or the thesis that options and actions should be evaluated only by the states of affairs that follow from them, or said conversely, that alternative states of affairs will be judged merely in terms of their components, disregarding the intentions and identity of those responsible. Thus, consequentialism is a broad term that covers both different modalities of utilitarianism and other teleological ethics not committed to the principle of utility.

Consequentialism relates ethical decision-making to an analysis of the probable consequences or outcomes of different options and actions, with the correct action being that which produces the best solutions. One of the best-known forms of consequentialism specifically is utilitarianism, considered the greatest good for the greatest happiness. Other outcome measures used in health decision-making include cost-effectiveness and quality of life, which are measured in healthy life years and years of life with disabilities. Generally, proponents of consequentialism do not make much use of principles because they are very difficult to identify, prioritize, and apply, and in any case, what is most

What interests them in moral decisions is the results. Perhaps this abandonment of principles opens consequentialism to the classification of "the end justifies the means," such as the fact that individual human rights could be sacrificed to achieve a social goal.

Principlism, as its name suggests, uses ethical principles as a basis for making moral decisions, applying them to particular cases or situations to determine what is right, taking into account rules and consequences. It has greatly influenced recent ethical debates, particularly in the United States. Four principles have been identified as the most important for decision-making in medical practice: respect for autonomy, beneficence, nonmaleficence, and justice. The priority of respect for autonomy is a reflection of Western liberal culture and is not necessarily universal, hence conflicts may occasionally arise.

In relation to virtue ethics, it focuses less on decision-making and more on the character of those who make them, as reflected in their behavior. A virtue is a type of moral excellence, such as compassion, but also honesty, prudence, and dedication. A doctor who possesses these virtues is more likely to make good decisions and implement them appropriately. However, virtuous people may feel unsure of their decisions in particular situations and even make mistakes.

From the perspective of the non-rational approach, obedience, imitation, feeling or desire, intuition, and habit are highlighted. We understand obedience as a common way of making ethical decisions, especially among children and those who work in authoritarian structures such as military doctors, those who work for the police, some religious organizations, among others. Morality consists of following the

rules or instructions from authorities, whether one disagrees with them or not.

Imitation is similar to obedience, as it subordinates someone's opinionabout what is right or wrong to another person's, in this case, a role model. This is perhaps the most common way aspiring medical students learn medical ethics, in which consultants, senior physicians, are their models, and through observation and continuous learning and the assimilation of projected values, it is the paradigm of moral teaching to follow or imitate.

Feeling, or desire, is a subjective approach to decision-making and moral behavior. What is right emanates from the physician's internal feeling or what satisfies the desire to heal; conversely, what is considered wrong is what they feel is wrong or what frustrates their healing aspirations. In this case, the measure of morality lies within each person, and of course, it can vary greatly from one person to another, and within the same individual over time.

Intuition is the immediate perception of the correct way to act in a given situation. It is not systematic or reflexive, but rather guides decisions with a simple moment of discernment. Like feelings and desires, intuition can vary greatly from one individual to another, and in the same person over time.

It's important to remember that habit is a very effective method for decision-making. However, there are harmful habits, such as lying, and good ones, such as telling the truth. On the other hand, situations that seem similar may require very different decisions, so it cannot be relied upon completely.

It is important to note that none of these approaches have achieved universal approval; some people have preferences for the rational approach to ethical decision-making, while others prefer the non-rational approach.

and this is explained by the fact that each has its strong and weak aspects.

Within the spectrum of difficulties encountered in medical decision-making, we find individuals who are unable to make decisions for themselves, for example, infants, people with debilitating mental conditions, neurological or psychiatric problems, or those who are unconscious or in a coma. These cases should have representatives who assume responsibility for choosing treatment. According to medical paternalism, the physician would be the appropriate representative to represent the disabled person, and may consult with family members about therapeutic options, but the physician is the one who makes the final decision. In contrast, physicians have gradually lost this authority in many countries, and are able to make decisions for the patient only when a legally designated representative cannot be located, which frequently occurs in emergency situations.

The WMA Declaration (WMA, 2015, 35) on the rights of the patient states the following as the doctor's duty in these circumstances: "If the patient is unconscious or unable to express his or her will, the consent of a legal representative should be obtained where possible; if one is not available and medical intervention is urgently needed, the patient's consent should be assumed, unless it is obvious and beyond doubt, based on previous statements by the patient or his or her previous conviction, that he or she would refuse intervention in this situation."

Problems arise when those who claim to be the appropriate representatives or family members fail to reach an agreement or their decision is not the best for the patient. The physician may serve as a mediator, but if disagreement persists, the issue may be put to a vote or the oldest family member may be allowed to decide. The criteria to be used in treatment decisions for an incapacitated patient are their preferences - if they were known - as is the case with advance directives.

that is, the unilateral declaration of will made by a person of legal age or emancipated, with full capacity for enjoyment and exercise, through which, privileging the principle of autonomy, he or she indicates in advance what he or she wants for himself or herself in relation to health care and treatment, in case he or she finds himself or herself in a given situation that does not allow him or her to express his or her wishes in this regard, particularly in the case of a terminal illness derived from a natural process or as a consequence of an accidental event. Difficulties arise when his or her wishes are unknown, having to decide on what would be best for the patient, taking into account the diagnosis, prognosis, values and information emanating from important people in the patient's life, naturally, all of this is less accurate than if the patient had left specific instructions about the treatment, because it allows us to have a vision of the patient's life in general, and what he or she would decide in his or her current situation.

Patients with psychiatric or neurological disorders, who represent a danger to others or to themselves, pose very difficult ethical challenges, imposing respect for their Human Rights, especially the right to freedom, but despite this, they often must be locked up or treated against their will, distinguishing between involuntary and voluntary confinement, there are those who defend the rights of these patients to refuse treatment and within the legitimate reasons for refusing it we find negative or painful experiences in previous hospitalizations or serious side effects produced by psychotropic medications, therefore, the doctor must ensure that the confinement of these patients is because they are truly in danger and not just because they are a nuisance or inconvenience to their relatives.

We have observed a worrying metamorphosis of attitudes and values in medical practice, particularly in the collection of medical fees. In this regard, the Dictionary of the Royal Spanish Academy defines fees as

honorarius, which serves to honor someone, perk or honorary salary, amount of the services of some liberal professions. Considering the above, one of the most delicate areas of the medical discipline is cardiopulmonary resuscitation (CPR), located within medical emergencies, although, in public and private health centers, this measure is administered free of charge to the dying patient, who is usually assisted with little chance of survival, without being able to guarantee the success of the

CPR is performed due to the random nature of the medical procedure. CPR is performed for multiple reasons: humanitarian, ethical, and legal. These latter are established in our Venezuelan Penal Code (CPV) under the provision of emergency relief, in Article 438, and also in the Medical Practice Law (LEM).

Considering the inherent randomness of the medical care contract, the success of this heroic measure cannot be guaranteed, as the chances of failure generally outweigh those of success, creating a great imbalance if one were to try to judge the doctor on this action.

A similar requirement applies to other professions that risk their survival or health to save lives, such as firefighters, without the obligation to value some lives more highly than others, since all must be rescued and cared for, respecting equality before the law, as established in the Declaration of Human Rights.

Now, in the event that it was decided to judge the doctor for using the

CPR and evaluate their performance, this would further complicate the picture by measuring whether their performance was diligent, prudent and compliant with the rules. Theoretically, in those cases where an injured person presents himself at a private clinic without the means to pay, he could be subject to a delay in receiving this assistance, violating the right to life and health established in the Constitution and International Treaties, and losing the humanism that should characterize this science. In this sense: (CRBV, 1999, 35) Article 43: "The

The right to life is inviolable. No law may establish the death penalty, nor may any authority apply it. The State shall be responsible for the lives of persons who are deprived of their liberty, performing military or civil service, or subject to its authority in any other capacity." In addition to the constitutional text, (Universal Declaration of Human Rights, 1948) states in Article 3: "Everyone has the right to life, liberty and security of person."

Physicians have long been part of a profession that has traditionally functioned hierarchically, both internally and externally. If we examine from an internal point of view, there are three overlapping ranks: the first differentiates between specialties, in which some are considered more prestigious and better paid than others; the second is academia, having more influence than private or public practice; and the third is related to the care of specific patients, finding that the physician who provides primary care is at the top of the ladder, while others with greater authority or knowledge serve only as interconsultants, unless the patient is directly referred to them for their care.

Medical professionals have always treated each other as members of a family. However, the interpretation of this requirement may vary depending on the country and time. When fees for services rendered were the primary or only form of remuneration for physicians, there was a tradition of so-called professional courtesy, which exempted colleagues from charging fees. This practice has become obsolete in countries where reimbursement is provided by an insurance company or other organization, as well as currently in Venezuela, where it is an ethical standard with no criminal or civil penalties.

In addition to the requirement to treat a colleague with respect and work cooperatively to maximize success in patient care and

provide good medical practice, the WMA International Code of Medical Ethics contains restrictions on the relationships of physicians with their colleagues: receiving payment of fees or other emoluments for the sole purpose of obtaining patients or referring a patient to a particular establishment, refraining from attracting patients from their colleagues, there being an obligation to report doctors of weak character or deficient in professional competence, all of which is established in the International Code of Medical Ethics of the World Medical Association (WMA, 2015, 32) which states that "the physician must inform the appropriate authorities about physicians who practice in an unethical or incompetent manner or those who engage in fraud or deception." However, applying this principle is not easy. On the one hand, a doctor may be tempted to attack a colleague's reputation out of jealousy in response to a perceived insult, or he may be reluctant to report another doctor's misconduct out of friendship or sympathy. The consequences of the report can be very damaging to the accuser, subsequently generating hostility on the part of the accused and very likely other colleagues as well.

In Lens's criterion (1997,273)Several studies have suggested that 5% of practicing physicians could be considered problem physicians, and although there is no agreed-upon definition, it is a term that has been used to encompass a wide range of behaviors, including physical and mental impairment, substance abuse, inappropriate sexual contact, and professional incompetence. Most of the literature has addressed efforts to rehabilitate disabled physicians, but little has been written about the underlying causes, methods of identification, and prevention. Many medical students are unprepared for the arduous tasks of undergraduate and graduate education and struggle with the combination of heavy workloads, clinical uncertainties, and the likelihood of adverse outcomes. This pressure can lead to a

inappropriate behavior unless students receive support and develop good coping skills

The doctor-patient relationship raises a number of issues, such as respect for confidentiality, privacy, and fidelity, which merit careful attention. Their protection is essential to maintaining the patient's dignity. Recognition and respect for their rights can guarantee the principle of autonomy, under which the patient assumes the right to make decisions based on their own interests and values.

It could be stated that in the pursuit of professional excellence, two fundamental requirements must be met: correctness and kindness. The first refers to adequate training in the professional formation of the doctor and the second condition refers to the physician's morals, his human sensitivity and the reflection of his own ethical values in the acts he performs, admitting that both expertise in the art of healing and kindness in the actions of the doctor make him good.

The Declaration of Geneva requires the physician to be primarily concerned with the health of the patient, and the International Code of Medical Ethics of the World Medical Association (WMA, 2015,42) stipulates: "…. The physician owes his patients his complete loyalty and all the scientific resources available to them."

Many physicians, especially those working in the public sector and emergency areas, often cannot choose which patients they treat. Some are violent and pose a serious threat to the physician's own safety and to the entire healthcare team. Others can only be described as offensive in their antisocial attitude and behavior. In light of this, physicians are expected to make extra efforts to establish and maintain therapeutic relationships. With patients like these, physicians must balance responsibility for their own safety and well-being as well as that of their staff with a duty to promote the welfare of the patient.

The care of patients with HIV/AIDS type infections poses another challenge to the principle of respect and equal treatment, there are several reasons for this, because the care of these patients could represent a threat to the life of whoever must handle them, take samples, perform punctures, catheterizations, operations, biopsies, among others, where doctors in certain cases may hesitate to perform invasive procedures, due to the risk of an accident at work due to accidental puncture and contagion, however, we must emphasize that the codes of medical ethics do not make exceptions for patients with infectious-contagious diseases, the duty of the doctor is equal treatment.

Additionally, the doctor-patient relationship is intimate in nature, which can lead to sexual attraction. In recent years, many medical associations have reaffirmed the prohibition of sexual relations between physicians and their patients. The reasons are as valid today as they were in the time of Hippocrates 2,500 years ago. Patients are vulnerable and place their trust in the physician. If the physician is unethical, the patient may not resist the physician's sexual advances for fear of not receiving the necessary treatment. In addition, the physician's decisions will be adversely affected by maintaining an emotional relationship with the patient. Similarly, this reason also applies to physicians treating family members, which is strongly discouraged in many codes of medical ethics. However, there are exceptions for physicians who work alone in remote areas and must provide medical care to relatives, especially in emergency situations or during CPR.

If we consider that the only purpose of medicine should really be the benefit of the patient, being fair and equitable for all of them, the negative selection of patients by companies that offer medical insurance and that privilege the admission of young and healthy individuals would be unethical.

avoiding the inclusion of elderly people or those suspected of being prone to disease.

We are faced with a lack of equity in healthcare when private clinics use tricks to defer payment of medical expenses legitimately claimed by insured persons. It is also unethical to grant low salaries to doctors or promote bonuses for those who use fewer financial resources for their patients in the public health system. In the case of patients, it is universally accepted as an injustice that they cannot freely choose their preferred treating physician and must adhere to the group of professionals selected by the insurer, who, out of necessity, have accepted low professional fees. (Rivero, 2008, 12)

1.2.8.-Organizational ethics of health institutions

In the medical practice of the public health system, there is a clear lack of equity, leading to injustice due to the excess of administrative resources, which results in a reduction in the funding allocated for medical care itself. This shows that supplies are frequently insufficient, especially in the area of medications, and consequently, the quality of care is sometimes poor.

Unlike public centers, in private centers care is provided according to the economic capacity of the patient, which is not a responsibility of these consortiums, being considered a lack of ethics of the health care system of the country, in the same way when a patient is discharged regardless of his clinical situation, because he has exhausted his economic resources or when the concept of productivity is promoted, that is, the doctor considered as the best or most respectable of the group is the one who uses the resources and facilities more by indicating laboratory tests, imaging or others, violating the principle of justice and that of non-maleficence, in addition, the existence of Bioethics Committees in the

health centers does not mean that they work, a situation evidenced in a Mexican hospital when a plastic surgeon "A" offered to resolve a surgical case, although the patient had dealings with other doctors "B" and "C", if the patient's family deposited a large amount in the bank account of doctor "A", the director of the clinic, upon learning of the situation, tried to dismiss the doctor but was unsuccessful because the institution considered him to be a very productive professional. (Cubellum, 2004, 28)

Situations are reported in the private practice of medicine, where doctors allegedly evaded the maximum amounts established by insurance companies, especially for surgical procedures, by entering into prior contracts and collecting payments from patients before their arrival at the private health center. The doctor then personally paid the clinic and the rest of the medical team. These are situations that expose the weakness of ethics in the face of social constraints in a given economic situation, leading to the abandonment of all ethical principles, fundamental pillars in a profession linked to the promotion of health and life.

Incidentally, it should be noted that in situations of dictatorship, profound changes in social relations can occur, breaking down the so-called solidarity of peers, producing a frightened, autistic society that sees the other as an informer or potential enemy. This leads to a change in autonomy, imposing a heteronomous morality, subject to external power that prevents the free development of its nature, in a context where there is no justice.

The above is of vital importance, because the exercise of autonomy allows us to denounce and safeguard social ethical values, and within them, those of medical practice. However, it is important that when democracy and constitutional guarantees are restored, medical associations and colleges issue ethical sanctions against those who committed such abhorrent acts.

crimes avoiding silence, as well as the absence of judicial conviction and impunity, at this point, it is essential to note that university medical education should consider adhering to human rights organizations and condemn the collaboration of doctors in unethical practices.

Emphasizing that as long as a country invests less than 3% of its gross domestic product in health services, its capacity in this area will always be insufficient, since many of the problems in medical practice are complexly related to ethics, health investment policies, the environment, and the current historical moment.

1.3.-Artificial intelligence in the doctor-patient relationship

Artificial intelligence (AI) is considered one of the technologies with the greatest potential to transform various areas of society. In the medical field, AI can have a significant impact on the doctor-patient relationship, enabling more personalized and efficient care; however, it also presents ethical and social challenges that must be considered. First, the advent of AI can substantially improve the diagnosis and treatment of diseases, providing tools that allow for a more comprehensive analysis of a patient's medical data. AI systems detect patterns and analyze large amounts of information that would be very difficult for a human to handle, allowing doctors to use these tools to make more accurate and personalized decisions regarding treatment.

On the other hand, the emergence of artificial intelligence in the doctor-patient relationship would affect the emotional and trusting bond that should prevail within it. It is important to remember that medicine is a field that involves a great deal of emotions and that, although artificial intelligence can help in the diagnosis and treatment of diseases, it should not replace the bond.

The human relationship established between doctor and patient; the latter may feel uncomfortable or insecure about receiving a diagnosis or treatment from an artificial intelligence system and may have difficulty understanding how these decisions were made. (Patroni, 2021, 35)

Another challenge that arises with the arrival of artificial intelligence in the doctor-patient relationship is access to the personal medical information collected and processed by these technologies. Although most algorithms are designed to meet security standards,and data privacy, it remains a challenge to ensure that each patient's medical information is protected, with access restricted only to medical personnel associated with the patient and is not used inappropriately or for commercial purposes.

The use of artificial intelligence in the doctor-patient relationship raises a series of ethical and legal issues that must be addressed responsibly to avoid medical malpractice. Some of the main ethical issues arising from the use of this technology in the doctor-patient relationship are the following:

1. Privacy: When collecting and analyzing large amounts of medical data, it is important to maintain medical confidentiality and comply with data privacy laws.
2. Algorithm bias: The algorithms used in artificial intelligence can be biased by the data sources used to train them, which can lead to poor and negligent decisions.
3. Fallibility: Although artificial intelligence has proven to be an effective tool in early disease detection and accurate diagnoses, it may also not be infallible and may make errors in interpreting medical data.

4. Liability: When artificial intelligence is misused and results in medical malpractice, it is necessary to establish the liability of the parties involved.
5. Ethics in the use of patient data: Companies and organizations that use artificial intelligence in the doctor-patient relationship must act ethically and transparently to avoid the misuse of medical information.

While the use of artificial intelligence in the doctor-patient relationship has great potential, it also poses significant risks. Therefore, these risks must be addressed from an ethical and legal perspective to ensure that the technology is used responsibly and that medical malpractice does not occur. There are also some potential dangers arising from the use of artificial intelligence in the doctor-patient relationship:

1. Lack of empathy and loss of personal contact: Although artificial intelligence can help doctors make informed and accurate decisions, it lacks the empathy and human warmth that patients need. Therefore, patients may feel that they are being treated as objects and not as human beings with emotional needs, leading to a communication barrier and failure to disclose vital information to reach an accurate diagnosis.
2. Data Error: Artificial intelligence can process massive amounts of user data, but if the information entered is not accurate or if there is a glitch in the system, it could lead to poor performance.interpretation of the situation and an erroneous decision, consequently, to an erroneous diagnosis and a failure in treatment.
3. Overreliance on technology: By relying too much on artificial intelligence to guide medical decisions, doctors can lose touch with patients and their physical and emotional condition,

which could lead to an incorrect diagnosis or failure to detect serious problems.

4. Legal liability: Although artificial intelligence could assist doctors in decision-making, the latter would be responsible for the final choice, as well as for the information provided under ethical guidelines. If something goes wrong, the doctor would be legally responsible for the decisions made.

Artificial intelligence could improve medical care, but doctors must be aware of its limitations and ensure that patients feel valued and cared for throughout the process.

Another issue related to artificial intelligence in the digital age in which we live is that privacy and data management have become a topic of great interest. The use of these tools in the medical field has generated additional concerns, since the doctor-patient relationship is based on trust and the protection of the privacy of the patient's personal information. We know that the proper management of patients' personal data is essential for adequate medical care and scientific research. While artificial intelligence could be used to analyze a large set of data and estimate disease risk or assist in disease diagnosis and prevention, questions arise about the applications of artificial intelligence related to its use and disclosure of personal data, and whether the results derived from its use would be accurate and ethical. (Patroni, 2021, 35)

Healthcare institutions and companies that use personal data must implement security measures to prevent information leakage. Data protection has become even more important due to the amount of personal information exchanged across the healthcare network, especially with mobile health solutions and electronic health records. It's easy for cybercriminals to exploit it.

accomplished at stealing digital data, and most of the time they do so clandestinely, without the victims realizing it.

Furthermore, the use of artificial intelligence in medical contexts would pose the risk of bias and discrimination when analyzing data. What would happen if artificial intelligence made errors that affected different races or genders in different ways? If we assume that artificial intelligence, which is a human creation, is trained with biased and incomplete data, the results will consequently be biased and incomplete. Issues of privacy, manipulation, and discrimination should be addressed before the widespread use of artificial intelligence in the medical sector, and the healthcare industry must work hard to ensure that its benefits outweigh the risks and challenges.

In addition to all this, medical professionals could face a set of ethical issues involving the use of artificial intelligence. Patients should always be adequately and sufficiently informed about the technology used to diagnose and treat their conditions. Healthcare providers' confidentiality obligations would be jeopardized, perhaps in aspects that had not been previously measured or evaluated.

Thus, the problems related to data privacy are extensive and are only growing today. Healthcare professionals have a responsibility to clearly assess the potential risks and benefits of using artificial intelligence in healthcare to properly balance technological progress and patient care. Only through the proper and responsible use and management of data and an ethical commitment will true progress be born, especially in the medical field, which demands high standards of technological and ethical rigor. Confidentiality in the use of data, and especially in the doctor-patient relationship, is a critical issue today, the challenge

Now is the time to find effective solutions that meet both the need for superior medical care and the inalienable right to privacy.

CHAPTER II

MEDICAL MALPRACTICE AND LEX ARTIS. MEDICAL ACT. IATROGENIA.

In this chapter, we aimed to analyze and explore the concept of lex artis or the law of art in medical practice, emphasizing the importance of its application to ensure quality medical care and minimize the risks associated with medical errors.

Lex artis, in its broadest sense, refers to the set of rules, principles, and protocols that govern medical practice, established by the scientific community and supported by the most up-to-date scientific evidence. It is based on the principle of beneficence, which seeks the well-being and health of the patient, and the principle of non-maleficence, which implies not causing unnecessary harm.

However, reality shows that despite regulations, medical practice does not always meet expected standards. Medical iatrogenesis, understood as the harm or negative effects caused by medical care, has been a source of concern and widespread debate in the field of bioethics. These adverse effects can result from medical errors, negligence or inaccuracy in diagnosis, inappropriate treatments, or even decisions based on economic interests.

Medical errors, understood as errors or failures in the practice of medicine, can have serious consequences for both patients and healthcare professionals. In addition to the impact on patients' health and well-being, these errors can lead to legal claims, damage professional reputations, and even create a climate of distrust in the healthcare system.

The purpose of this chapter is to address the importance of lex artis in medical practice, as well as to examine medical iatrogenesis and the risks associated with medical errors. This analysis is essential to understanding current challenges in the field of medicine and to provide proposals and recommendations that contribute to improving medical practice and ensuring quality, ethical, and safe care for patients.

2.1.-Medical malpractice

Medical malpractice is defined as an unintentional, avoidable error, a defect in the application of methods, techniques, or procedures in the different phases of a physician's work, which results in a foreseeable impact on the patient's health or life. According to Martín-Polo (2011, 65), for medical malpractice to be established, three essential elements must be present:

- Evidence of lack
- Evidence of damage
- Causal relationship between both.

There are a multitude of causes that can contribute to the occurrence of medical malpractice, however, the most notable due to their common occurrence are the following:

1. Inadequate doctor-patient relationship. It has been proven that when there is a good relationship between a medical professional and their patient, medical demands are fewer, perhaps due to the patient's or their family's understanding of the condition, affability, or empathy for the patient's discomfort or illness.

2.- Incorrect preparation of a medical history. Although the latter constitutes a legal medical document through which the physician collects the patient's historical-biographical data and the physical examination of the latter in order to obtain a presumptive diagnosis, the absence of data will make it difficult to successfully access the knowledge of the nosological entity that affects him.

3.- Poor communication among the work team. The congruence and union of all the members of the health team is one of the fundamental pillars for the correct management of the patient, it is through the concatenation of data, the communication of eventualities, allergic possibilities, drug interactions, or request for urgent tests, which may alert the need to accelerate a procedure, readjust drugs or avoid

The need for expensive, risky, and unnecessary surgical interventions. Poor communication among team members will not only add more stress to the workplace, but also lead to a lack of empathy and mistrust that will impact the patient's recovery and healing.

4.- Unworthy working conditions and poor compensation for the work performed by physicians and other auxiliary medical staff result in a demotivated, resentful, outdated, malnourished workforce with a poor quality of life and at risk due to high social and job insecurity.

5. Inadequate patient follow-up. Periodic evaluations are especially important for patients with risk factors, a history of life-threatening conditions, or significant after-effects.

Medical malpractice refers to negligent or inadequate medical care that causes harm to the patient. From a legal perspective, it would be considered medical malpractice if it is proven that the professional failed to meet professional standards of medical care and caused harm to the patient.

2.2.-Lex artis in medical practice

The term lex artis comes from Latin and means law of art or technical rule of action of the profession in question, the health professional to act within the parameters of this law must master the subjects studied in his career, with the necessary and required knowledge to be able to practice medicine without recklessness, otherwise it would lead the patient to aggravate his condition with danger to his health and life, therefore the Venezuelan Code of Medical Ethics requires doctors to be constantly renewing and updating their knowledge to provide a better quality of health care, in this way the doctor can use all the most appropriate diagnostic means at his disposal,

interpreting and applying them for the benefit of the patient will also ensure that science prevails over economic criteria, favoring the selection of appropriate treatment, taking care of its application, compliance and monitoring.

The lex artis is used to assess whether the task performed by a professional has been correct or not, and whether it was adjusted to what should have been done, however, unfortunately it is changing, precisely because of the evolutionary nature of medicine, being subject to variations such as regional, specific circumstances, professionals and changes in legislation, since for example, it is not the same to treat a patient in a hospital where there are adequate means and instruments than in a village far from the city where the minimum resources are not available.

It is important to note that the principle of the law of art is usually applied to professions that require an operative technique; in the field of health, it indicates the technical rules for each type of similar medical act, adapting to the specific case. (Cibeira, 2004,45)

German doctrine states that medical indication and lex artis are two concepts that are strictly linked but essentially different, since while the medical indication responds to the "yes" of the treatment and determines the application of this or another measure, the lex artis or law of the art refers to the "how" of the procedure or method to be followed. However, there is a relationship between the medical indication and the lex artis, the former refers to the assessment made by the physician, whether preventive or prophylactic, surgical or curative, a fact that entails evaluating the risk-benefit binomial objectively foreseeable for the patient, while the latter will attempt to apply the orthodox technique. In such a way, a surgical intervention will conform to the lex artis when the technique that is accepted by the indication and due care is used, contrary, if a surgeon operates and does not do so with a correct technique, we would affirm that he has not observed the law of the artis.

art, calling into question his performance in relation to it. (Cibeira, 2004,45).

Understanding the above, the updating and renewal of knowledge should be the guiding principle of both medical schools, hospitals and state institutions that train medical personnel, in order to use all diagnostic methods considered appropriate for the benefit of the patient, avoiding errors, giving priority to scientific criteria, the indicated treatment and never the contraindicated one, with knowledge of the same and monitoring its application, the physician will follow international guidelines without forgetting the opinion of his own personal criteria based on his experience.

The following are considered to be elements of the lex artis: a duly qualified and accredited suitable professional, in addition to compliance with the legal requirements for the practice of his profession, such as completing the surgical record or number of interventions performed during his specialization, in order to avoid incompetence, having the necessary time for the study and analysis of the patient's condition, the diagnosis being a fundamental piece for the subsequent legal evaluation of liability, since a diagnostic error inevitably leads to erroneous action, distorting the law of the art and frequently culminating in judicial proceedings.

Since ancient times, judicial processes have relied on medical expertise and lex artis, as part of the tools to elucidate the commission of malpractice and although it has evolved over time, its origins date back to 1920 in England, when a doctor attended an emergency birth and powerless to resolve it, the expulsion of the fetus, placenta and maternal uterus occurred, with the subsequent death of the parturient three days later, for this it was necessary the expertise of the Queen of England's own gynecologist, concluding with the acquittal of the doctor but reproaching his actions for not having requested help from another colleague, although this situation is relative for several circumstances: Firstly, within the activity

medically, there must be different positions in relation to the convenience or not of a treatment, that is, there must be different criteria based on different scientific and academic postulates, secondly, the circumstances in which the act was carried out must always be taken into account.

It is also important to point out that the application of lex artis is not possible in unstudied, unknown or unforeseen situations in medical science; on the contrary, what it requires as a condition is that any doctor would act in a similar manner when the same conditions were given, with the exception of professional freedom, considering in the medical act that the correct technique has been applied, in an appropriate manner, respecting the essential principles that tend to its normal development, in compliance with deontological standards, the science or treatise on duties, an eminently practical branch of ethics, also called professional morality. (Cibeira, 2004,45)

The lex artis indicates the technical rules for each type of similar medical act, adapting it to the specific case, since the reactive factor of each individual is different, so the content of the lex artis is variable, although the main core is immovable and defined before the medical act is given, the doctor is obliged to adhere to it, a certain margin of freedom of the classic procedure is considered admissible if it is a matter of investigating, of making scientific progress, because otherwise medicine would have remained immobile since ancient times, making its advance impossible, therefore, in the assessment of the law of art, a technical, scientific, legal, human study must be carried out in order to find or discard the causal element, demarcate the result achieved by the medical act, whether or not it conforms to medical science or if there have been circumstances that break the link of causality such as force majeure or fortuitous event.

Currently, society is witnessing a steady increase in complaints regarding medical services rendered, which patients deem substandard. These complaints are filed before civil and criminal courts or before institutions. These complaints have diverse objectives depending on the nature of the organization to which they are submitted. The dissatisfaction generated by the complaint, lawsuit, or report can be of a diverse nature, depending on the area in which the violation originates, whether due to noncompliance with the provisions of the lex artis of medicine, violations of health, civil, or criminal legislation, or violations of ethical principles.

It is known that the advancement of medical science and technology would imply an increase in the effectiveness of diagnostic and therapeutic methods for the benefit of patients, but simultaneously the risks would multiply, representing a real challenge to determine the degree of responsibility of the doctor, which can be sought by measuring the margin of admissible contingency in the medical act and having as a guideline for this measurement the law of the art of medicine, considering the interpersonal dimension of the care process, whose referential parameters are the ethical principles and applicable laws. (Cibeira, 2004,45)

As a general rule, morality is closely related to the legal system, since the latter tends to preserve values, such that the requirement to comply with obligations freely acquired by the medical professional becomes a rule of coexistence of a legal nature, that is, in many areas the law accepts morality as a reference for its provisions, therefore the coexistence of norms of moral and legal scope is possible, the non-compliance of which is the reason for most claims.

An age-old legal axiom teaches that where there is society, there is law, and it has always been a fundamental concern to define rules of conduct to provide security and certainty to social dynamics, by fairly addressing accusations arising from their non-compliance.

The doctor-patient relationship is contractual in nature, consequently, it implies certain rights and duties for both, legal freedom would include the possibility of choice, prescriptive freedom is applicable to the doctor, while therapeutic freedom applies to the patient, the doctor is free to study, diagnose, evaluate and decide on more favorable alternatives depending on the case, the patient may or may not go to the doctor, choose the one of his preference, request other opinions and accept or reject the proposed treatment.

Thus, professional liability is established when there is an action or omission committed with full freedom and capacity, voluntary or involuntary, which causes certain damage and is known as medical malpractice. This implies being responsible for one's own acts and, in some cases, also for those of others, as occurs when it comes to actions or omissions of nursing staff and doctors in training, who act incorrectly with the instructions they have received.

When analyzing a claim, the physician's actions must be assessed by recognizing that the activity of health professionals is governed by a fundamental principle of freedom, which is limited by the best benefit for the patient. Therefore, the specific conditions under which the service was provided must be reviewed, since in certain cases, risky behavior by the physician is required, depending on the severity of the patient's condition, the consequences that the medical intervention could have on the patient's physical and mental well-being, as well as the ethical principles in accordance with which care is provided. This freedom of action must be justified through an impartial analysis by the physician of his or her knowledge and abilities in the intellectual and practical fields, since failure to take it into account could lead to harmful actions that require reparation. (Cibeira, 2004, 45)

Thus, in order to attribute a harmful result to reckless medical conduct, it must be foreseeable and avoidable, being a direct and immediate consequence of the active or passive conduct of the doctor, which requires that the latter has created a risk or increased a pre-existing one, since precisely what the rule seeks to avoid is its materialization.

A result should not be attributed to medical conduct when the victim's fault is the sole responsibility of the patient, even less so in cases where the patient fails to obtain the prescribed treatment, abandons it, or fails to inform the doctor of his allergies to certain medications. Therefore, it is important to mention the theory of natural causation. When complex causal courses occur, that is, when the defendant's conduct contributes to a typical result, in addition to other causes attributable to a different person or a fortuitous event, it is usually considered that if this latter concurrent cause existed prior to the defendant's conduct, such as a specific illness of the victim, this would not interfere with the possibility of objective imputation. If it occurs later, it may prevent such imputation when this supervening cause is something completely anomalous, unforeseeable, and foreign to the defendant's behavior.

It would be considered inappropriate to declare the doctor's criminal liability when the result has occurred by chance or fortuitous event, that is, as a consequence foreign to the action of the physician who did not foresee it because it was simply unforeseeable, thus escaping any possibility of being avoided, such as those injuries produced by a medication considered harmless as a recommended treatment for an illness, or the taking of a biopsy that can determine the abortion in the woman, in the case of amniocentesis. (Cibeira, 2004,45)

The lex artis ad hoc is a normative component of the breach of the duty of care, the central core of imprudence is constituted by its

violation, with the obligation to determine whether it was serious, minor or, on the contrary, there was no evidence of negligence.

The protection of legal assets in health is more difficult than in other spheres of society, because medical work is based on the Hippocratic oath, seeking to heal at all times, opening two ways in the protection of legal assets such as health and life, by presuming the absence of fraud, it is deduced that most actions will be imprudent, there being the possibility that some medical treatments do not have the purpose of restoring health, as would be the case with cosmetic surgery, or the performance of abortions for economic reasons in those countries where legislation allows it.

Thus, in medical practice, according to Rodríguez (2004,370) "we find assets that can be injured: individual assets such as life or physical integrity and collective assets such as public health, with life being the legal asset par excellence protected by criminal law."

2.2.1.-Medical practice and the Law on the Practice of Medicine.

It is important to highlight that any professional action in different areas may generate liability towards others, hence in medical practice there is criminal, civil, administrative and disciplinary liability, whether in isolation, combined or concurrent as established in article 107 of the Law on the Practice of Medicine (2011,34):

Article 107 of the LEM: "Disciplinary and administrative sanctions shall be applied without prejudice to any civil or criminal liability that may arise as a result of action, omission, incompetence, imprudence, or negligence in the exercise of their profession." This same legal instrument specifies sanctions for each type of liability in Articles 105 and 106. The former refers to disciplinary sanctions and shall be applied in accordance with Article 108, while Article 106 mentions administrative sanctions.

In the opinion of Méndez (1994,26) "…curiously in Venezuela, unlike other countries, there is a predominance of criminal lawsuits instead of civil claims..," for this reason, it is recommended to cultivate an adequate doctor-patient relationship in order to reduce the possibility of unnecessary claims, since it has been observed that a solid relationship of trust based on honesty and constant evidence of selfless attention from the doctor to the patient are fundamental elements to prevent a complaint from the patient or his family.

2.2.2.-Medical dyspraxis.

The term "medical dyspraxis" means an alteration in medical practice, while the term "medical malpractice" should only be used when a judge so determines. In the latter case, the doctor causes harm as a result of his or her mistaken action, misuse of a technique, inexperience, or lack of knowledge. Similarly, there is also the concept known as honest error, which refers to the fact that no doctor would actually intend to cause harm, but due to the existence of multiple factors at a given time, medical practice may be affected. (García, 2005, 25)

2.3-Iatrogenesis

There are a variety of positions regarding this concept, normally the doctor who causes iatrogenesis is considered unaccountable, although there are those who claim that it is not synonymous with medical error, while others claim that it is, and although the term iatrogenesis does not yet appear in the Dictionary of the Royal Academy, nor in medical dictionaries, its adjective is found: iatrogenic, referring to any alteration of the patient's condition caused by the doctor, when applying a therapy, when this is correct. That is to say, it is the product of an unforeseen event, which escapes any possibility of being avoided by the usual means of individual care or

collective and in principle does not derive from the will or fault of the doctor. (Albújar, 2004, 11)

2.3.1.-Classification of iatrogenesis:

1. Positive iatrogenesis: This occurs when the alterations caused to the patient are harmless, such as using saline solution to expand a dehydrated patient slightly above the range established in the manuals without causing any harmful symptoms. Since none of the elements of guilt are evident, it could therefore hardly be classified as malpractice.

2.-Negative iatrogenesis: It occurs when the patient's condition suffers some damage due to the medical action, and is subdivided into two types: necessary or unnecessary, as for the first type, the necessary negative iatrogenesis, the doctor is fully aware of the risk of harm, it is something expected, foreseen, that does not come as a surprise and he recognizes it as a possible consequence of his actions in favor of the patient, in his decision to cure he has weighed the risk / benefit. Some of them would be the urinary infection caused by the installation of a Foley catheter to urinate, also the sensation of abdominal pain as a side effect of an antibiotic to treat a respiratory infection, and also the appearance of thrombosis in the lower limbs after hip surgery, while in unnecessary negative iatrogenesis, the medical action has caused damage that did not have to occur, it is a consequence of ignorance and ethically inadmissible, but it is excluded from malpractice, since the elements of guilt do not exist in it, it is also called a medical infraction or fault.

It is important to mention that in the doctor-patient relationship, there are elements of communication such as verbal or corporal expressions, through gestures or attitudes, being relevant to mention iatrolalia, understood as the damage caused through words that can provoke in the patient feelings of humiliation or ridicule, doubt, disgust,

Distrust can foster hypochondria and damage the patient's self-esteem. Just as a hasty and insufficiently verified diagnosis can become fixed in the patient's mind and be very difficult to rectify later, inadequate, omitted, or insufficient information, ambiguous or distressing, the use of popular terms that imply poor prognoses, or a lack of discretion can be a factor. When doctors conduct medical reviews with the entire medical team in hospital wards, discussing diagnoses and the treatment of patients, they generally violate medical confidentiality. All of this leads us to reflect on the hypothetical shortcoming that exists at the level of medical training and the health system, since the teaching and conduct in hospitals and clinics are often inherited from the way this practice is universally carried out in other latitudes.

2.4.-The medical act. Risks and possibility of errors

In Vincent's opinion (2003,1051) "...estimating the exact number of medical errors is difficult, because many factors converge, one of the main ones being the so-called black figure, that is, those not reported or denounced, in the United States (US) 42% of the general population at some point has been susceptible to an adverse event caused by doctors." In Australia, 2.4 to 5.6% of hospital admissions have been reported due to prescription or medication errors, Holland has documented 180,000 deaths and adverse events caused by these and Venezuela lacks figures on this subject. (Rivero, 2009,310)

Throughout history, societies have accepted the existence of physicians as a benefit, recognizing their dedication, willingness to serve, and efficiency. However, the practice of medicine entails risks that can harm legally protected rights. It is important to recommend that physicians be cautious and anticipate the possible results of the conduct to be used on the patient, unfortunately, given the physiology of the patient.

The human body and therapeutic action are always present in one way or another, chance, medicine being an inexact science, not all individuals will respond equally. (Hall, 2011, 717)

CHAPTER III

DEHUMANIZATION FACTORS AND EDUCATION ALAS GENERATORS OF MEDICAL MALPRACTICE

Bioethics, an interdisciplinary field that addresses ethical dilemmas in medical practice, has shown a worrying trend toward dehumanization in the field of medicine in recent decades. This fact motivated us to incorporate it as part of our research topic, to which we dedicate this chapter. Dehumanization is related to multiple factors, including medical narcissism, burnout syndrome, medical teaching and its relationship with the hidden curriculum, as well as the difficulty in dealing with aggressive patients, among others.

Medical dehumanization is a gradual and complex process that manifests itself in the loss of fundamental human values, such as empathy, compassion, and respect. It can result from an overly scientific and technological approach to the detriment of care focused on the patient as a unique and dignified human being.

In this regard, medical narcissism constitutes a significant problem in clinical practice. This concept refers to a narcissistic or egocentric attitude adopted by physicians, placing their own interests and personal recognition above the patient's well-being. It can be a consequence of professional training and the prestige associated with the medical profession, contributing to the dehumanization of care and creating an environment unfavorable to effective communication between physician and patient.

In addition to the aforementioned, the presence of burnout syndrome in physicians is another factor that impacts the dehumanization of care. Burnout syndrome is characterized by the physical and emotional exhaustion of physicians as a result of workload, stress, and a lack of personal satisfaction or recognition in their work. This exhaustion can lead to a decline in the quality of care and an emotional disconnection from the patient.

Similarly, medical education and its relationship with the hidden curriculum also have implications for medical dehumanization. The hidden curriculum refers to the values, attitudes, and behaviors that are implicitly transmitted during medical training, often without realizing it. If the hidden curriculum emphasizes prioritizing technical aspects over humanization, it will foster dehumanized practice.

Furthermore, the difficulty in dealing with aggressive patients represents a significant challenge in the doctor-patient relationship. Verbal or physical violence from the patient can generate stress and negative emotions in the medical team, thus hindering the provision of quality, empathetic, assertive, and humane care.

For all the reasons mentioned above, we consider medical dehumanization to be a worrying phenomenon that must be addressed from different perspectives. Medical narcissism, burnout syndrome, medical education and its relationship to the hidden curriculum, as well as the difficulty in treating aggressive patients, are all aspects that require special attention to promote more humane and ethical medical care. In this chapter, we will delve into each of these topics and explore possible solutions to reverse this trend for the benefit of patients and healthcare professionals.

3.1.-Medical narcissism

Some personality disorders can affect the execution of good medical practice, one of the most important is the so-called narcissistic personality disorder, defined in the psychiatric manual of diagnosis and statistics of mental illnesses DSM-IV (2011,133) as a "... immense sense of self-importance, demand for excessive admiration and lack of empathy, perhaps analyzing this, medicine could fit very well, or be the ideal profession for narcissistic satisfaction."

Narcissist suffers from low self-esteem, but likes to attract attention to counteract his sense of inferiority, its prevalence is higher in men than in women, where feelings of grandiosity, superiority, selfishness stand out, the extreme variant of narcissism is the so-called perverse narcissism, which consists of the satisfaction of desires and needs at the expense of others.

Some doctors take risks more to demonstrate their expertise than to meet the patient's real needs. They may be pressured by commercial or corporate issues, or by work overload. Medical narcissism is characterized by a focus on the illness rather than the patient. A doctor-patient relationship is established, where the doctor controls everything in order to avoid anxiety and discomfort, as a self-protective mechanism. The most distinctive features of medical narcissism are feelings of superiority, authority, perfection, self-admiration, and arrogance.

The boundary between healthy and pathological narcissism would be healthy self-esteem. The pathological narcissist demonstrates an arrogant attitude and an attitude of being in total control, never doubting or showing his mistakes or fears, always acting as if everything were fine. (Rosenthal, 2005, 324). For the narcissistic doctor, the patient is reduced to a bed number or a medical record, virtually disappearing as a person, that is, what is known in psychology as objectification.

Thus, the doctor-patient relationship in these cases becomes asymmetrical; narcissism interferes with it: the doctor is strong and the patient is weak. Scientific medicine, on the other hand, tends to treat the human being necessarily as a measurable object and, in a way, objectifies them, sacrificing their humanistic essence for technology and clinical trials, thus dehumanizing them. Certainly, diagnostic methods will always be a support for the physician, but in no way should they replace a good examination.

clinical and anamnesis, allowing sufficient time to listen to the ailments of the patient, who after all is a being who suffers and asks for help. According to Cragno (2009,45) "it is advisable to redesign the health and academic system, because it has been proven that the lack of communication between doctor and patient or their family is the reason that leads to more than 95% of the demands in the medical field."

Likewise, the accessibility that patients currently have to the press or the Internet does not help to balance the doctor-patient relationship. Although it is true that patients can provide information and have the right to exercise their autonomy, the bombardment of news from various unqualified sources can often generate anxiety and mistrust, proving dangerous in the long run, to the point of documenting so much about their own illness and, guided by their own narcissism, of being capable of replacing the doctor.

Within the human mind and actions, there exists free will, which grants the ability to decide between doing good or evil. Experimental research has shown how placing people in an adverse situation can influence their behavior, as the environment can alter the way we conduct ourselves. Individuals carry within them their own cultural, psychological, and intellectual qualities that characterize and differentiate them from others. Immersed in a complex social framework, full of social and economic demands, temptations, and difficulties, their behavior must often conform to certain conventions.

In this sense, the work of Professor Philip Zimbardo, written in 2008 entitled "The Lucifer Effect" is of interest. Its fundamental thesis is the theory of how good people can become evil. Professor Zimbardo tried to discover the origin of evil, based on his own personal and professional experience as a social psychologist, taking the Stanford prison experiment for this purpose, through behavioral observation.

between prisoners and jailers. In this experiment, he examined various triggers of evil, such as blind obedience to authority, determining that someone can be appeased or demoralized with words. He pointed to anonymity as a crucial element in harmful behavior, since it protects the identity of the sadistic individual, acting as a kind of mask, and the individual feels free, powerful, and protected from acting and continuing their actions. The so-called seed of evil develops in our brain when we dehumanize, attack, or fail to prevent the commission of an atrocious act, a crime, or something punishable. It appears to be related to the functioning of the limbic area of the brain. Some people do not evaluate very well those they associate with, and when individuals commit reprehensible acts without considering their future consequences, thinking only of the present, there is a risk of repeating these actions. (Zimbardo, 2011, 576)

In the analysis of the work written by Zimbardo, one of the concluding points noted is that preventing reprehensible behavior requires factors such as strength, determination, virtue, and vulnerability. In addition, he mentions the loss of the sense of individuality that subjects suffer when they find themselves submerged in certain social groups that stigmatize them, leading to a change in their behavior, which may produce blind and irrational obedience to authority, passivity in the face of threats from superiors or third parties, self-justification of their actions by which the individual tries to convince himself that he is right, even though what he is really doing is considered an outburst in the eyes of humanity, being related to rationalization, a psychological defense mechanism that consists of justifying actions, generally one's own, in order to avoid censure by trying to give a logical explanation to feelings, thoughts, or behaviors that otherwise would provoke anxiety attacks, guilt, or inferiority. Faced with an environment

Authoritarian, despotic, cruel, unhealthy—even the best person in the world can become a murderer. The above-described situation can happen to a doctor or healthcare team when a mistake, iatrogenesis, or malpractice is committed, and they try to avoid their own responsibility by justifying it. This explains the similarity with the thesis developed in the book "The Lucifer Effect." Faced with the worrying transformation of behavior in people considered good into malevolent individuals, Professor Zimbardo proposes a possible antidote: heroism. (Zimbardo, 2011, 576)

It is worth noting that medicine, a discipline that necessarily involves human interaction, is currently criticized and discredited for its tendency toward commercialism and dehumanization. Consequently, it is necessary to restore its positive image, based on the fundamental pillars of medical heroism, in order to limit the ruthless and often unjust attacks. This campaign promoting the virtuous and ideal practice of medical practice is supposed to contribute to a significant reduction in bad medicine.

The profile of the humane, good and heroic doctor should include the capacity for self-analysis, and the concern for acquiring a high level of professional training, great responsibility, self-denial and sense of duty, the ability to master one's own ego, for the benefit of the patient's health, humbly recognize the limitations in their field of action, promote and demand from the authorities the regular and systematic implementation of discussion tables with cases of errors, iatrogenesis and medical malpractice, seeking to correct failures and optimize medical act, avoiding being punitive or defamatory and promoting education aimed at updating treatments, as well as constant observation and reminder of the ethical field and the laws that govern the conduct and daily work of the medical professional.

3.2.-The dehumanization of medical practice

Dehumanization is the deprivation of the qualities that distinguish people as human beings. When compared to objects or animals, they can be considered incapable of feeling anything other than pain. Therefore, when the concept is adopted in the practice of medicine, it can be understood as the consequence of a scientifically rational model that deviates from human sensitivity. The medical act is a balance of several dimensions that encompass the anthropological and disciplinary aspects, involving training, professional practice, and social context, since it is regulated by scientific, technical, economic, administrative, social, and political determinants. (Ávila, 2017, 216)

The process of dehumanization is linked to the development of medical practice and its transmission through different models and paradigms, in which Hippocratic precepts are replaced by others, given by the economic imperative that advocates the efficiency and administration of health services, having to analyze it from the training of the doctor to the implementation of the medical act. (Rodriguez, 2006, 95)

The philosopher Edmund Gustav Husserl (1859-1938), founder of transcendental phenomenology, described the dehumanization of contemporary science as a consequence of the spiritual disturbance produced by the First World War. However, for some time now, some thinkers have argued that social dehumanization had its maximum expression in the millions of lives lost during that conflict.

Over time, combined with scientific advances, treatment has been found for many diseases, leaving the doctor-patient relationship in the background, leading to a dehumanization of health due to multiple factors such as the objectification of the patient, forgetting their personal traits, feelings and values, the absence of warmth in human relationships, the lack of recognition.

of the dignity of the patient and equality among all people, associated with an inadequate power relationship, distrust in medical knowledge and false expectations based on past experiences.

The medical act, that is, the one where the doctor-patient relationship is specified, allowing for ethics and therapeutics, which aims to promote health, healing, prevention and rehabilitation, requires four characteristics for its fulfillment: professionalism, rapid execution, having as its objective the cure or rehabilitation of the patient and legality, developing in different stages namely: the anamnesis that includes the physical examination, interrogation, diagnosis, treatment and monitoring of the evolution of the patient. It can be classified as direct, indirect and documentary, the direct is that by means of which the cure or relief of the patient is desired and can be preventive, diagnostic, therapeutic or rehabilitative, the indirect includes research, experimentation and autopsy, while the documentary medical act complements the previous two and includes the medical certificate, the prescription or medical formula and the clinical history, the latter having evidentiary validity in legal proceedings.

Medicine has undergone changes that have disrupted its practice, some related to the health system, others to the economy, medical judgment, imperfect socialization, the physician's relationship with society, and scientific advances.

There are authors such as Thomas (2004,2880) who have considered that "...dehumanization begins at the training level, the young student from the moment he enters the classroom finds an academic demand that implies a radical change in his behavioral patterns and in his lifestyle, exacerbated even more when he begins clinical practice, in which he must fulfill commitments to care, study and deepen the topics", where the burnout syndrome can be considered as a predisposing factor to dehumanization, characterized as a

feeling of exhaustion, disappointment, loss of interest and effectiveness for academic or professional activity, has been identified in multiple studies carried out on medical students both undergraduate and postgraduate, detecting that this population is especially vulnerable to suffer psychiatric symptoms and that they are affected by the environment during their studies, and in the future will be associated with negative consequences at work and personal levels affecting the treatment of their patients, therefore, it is important to detect these symptoms early in students to generate early interventions that really impact and raise awareness about stress and burnout, avoiding the appearance of symptoms that can manifest as a feeling of being exhausted by the demands of study, perception of incompetence, cynicism and brazen attitude, among others. (Pereira, 2015, 353)

There are factors in both undergraduate and graduate medical studies that induce dehumanizing attitudes, and this can begin with the observation of unethical behavior in teachers, including mockery that ridicules their patients, in this way, students find a great contradiction between the values that, according to what they are taught, a doctor should have and those they learn during their clinical practices, when this situation occurs, that is, receiving a teacher who deviates from ethical standards and shows mockery, abuse and dehumanization, "identification with the aggressor" occurs, which appears as a response to situations of anxiety in the face of a threat, the loss of the feeling of protection or being in the face of danger, at that moment the person moves away from themselves and automatically transforms into the image that someone else has of them. (Frankel, 2002, 101)

On the other hand, there are circumstances that influence the ethical wear and tear of the doctor, such as inappropriate behavior of his tutors and teachers, changes in the values of the profession, clash of ideals with reality,

emotional overload resulting from contact with suffering, limitations of medicine, patients in difficult situations or with antisocial personality, aggressive patients, contradictions inherent to the role of entry into the healthcare system, healthcare consumerism and unrealistic patient expectations.

It has been described that expressions of cynical attitudes in medical students tend to increase as they progress in their careers. In fact, a study at Ohio University in the United States showed that the derogatory and cynical comments were not about situations related to their own training such as long study hours, fatigue or lack of social life, but about patients who they themselves did not consider to be good patients, and most of these comments were initiated by residents or specialists. (Testerman, 1996, 43)

In this regard, two models have been described to explain how medical students become cynical, the first is the intergenerational transmission model, according to which the behavior is transmitted to students and residents by faculty who are in turn cynical and abusive, the second is the professional identity model, in which cynicism is considered a temporary byproduct of the more disturbing and abusive aspects of medical education, which corresponds to the struggle to develop a professional identity while surviving demanding academic and clinical challenges in a complex and ambiguous ethical environment. (Loayssa, 2009, 646)

Some researchers interpret the use of cynicism as an adaptive mechanism to stress during medical school, which can be exacerbated by fatigue and responsibilities for which they may feel unprepared. In fact, both cynicism and black humor can play an important role in the psychological well-being and survival of students. Therefore, the type of ethical training is currently questionable.

imparted, suggesting rethinking it in the area of the doctor-patient relationship through theoretical-practical education that optimizes the understanding of the patient's emotional reactions and their psychopathological roots to achieve a better understanding and reduce possible rejection, excessive distancing and lack of empathy. (Wear, 2006, 454)

Based on the above, it is considered important that competency-based curricula in medical schools resume the teaching and deepening of the humanities and ethics to achieve not only training in knowledge and action, but also in being. Teaching must provide students with cognitive and emotional tools, skills, and attitudes to face challenges and problems. (Gaufberg, 2010, 1709)

3.3.-Relationship between Burnout and dehumanization of medical practice. Some authors argue that medical schools teach this science but ignore its art. Technology has currently surpassed moral understanding, and hospitals have become cold, impersonal labyrinths where doctors treat diseases, not patients. However, as a mitigating factor to this medical dehumanization, bioethics and the humanities in medicine have emerged. These studies firmly aim to treat patients as respectable people, with the right to be heard, understood, and assisted in decision-making. Ironically, evidence indicates that physicians also suffer from the dehumanization of modern medicine. In fact, there is evidence showing that being a doctor is not good for one's health due to the high incidence of anxiety and depression in this profession, with the suicide rate being higher among physicians than in the general population. In the United States, it has been estimated that approximately 15% of physicians will suffer from mental illness, addiction, or alcoholism at some point in their careers. The so-called burnout or psychophysical exhaustion has alarming growth rates in students, residents and doctors, the environment

Labor is also important, being more frequent in dehumanized environments, where profitability predominates with an unfair and bureaucratic health system, finding that these conditions are more accentuated in underdeveloped countries due to the lack and deficiency of material and human resources.

According to Christina Maslach and Michael Leiter, burnout is an indicator of the dissociation between what a person is and what they should be, because it represents an erosion of values, dignity, spirit, and desires, that is, the deterioration of the human soul. According to Theodor Ludwig Wiesengrund, Adorno, a German philosopher, sociologist, and musicologist, who in his book entitled "Problems of Moral Philosophy" investigated the burnout of doctors, calling it ethical violence, due to the cruel aspect of forced collective morality, since when an ethical norm becomes impossible to apply within an existing social condition, the result is ethical violence, finding that those institutions that ignore existing social conditions and rigidly push market rules, attack those who are expected to do the impossible to achieve it. (Wiesengrund, 2001, 224)

Although medicine is filled with many honest and upright people who provide optimal physical and spiritual work, there may be conditions that limit the ability of doctors to achieve and develop these goals. In some professionals, this can lead to cynicism, disappointment, loss of self-esteem and self-confidence, illness, and abandonment of ideals. It is curious to observe that institutions in general do not take into account the abyss formed between the ideals of the professional and the limiting conditions of the work. In this context, it is difficult to humanize medical practice. The answer points to the need for structural and cultural changes in the institutions where doctors work, but also activities that stimulate self-care, reflection, and development. Therefore,

Universities, in conjunction with healthcare centers, must generate opportunities that support and guide physicians in their pursuit of well-being and satisfaction. Related to the above, among the particularly emotionally unhealthy work areas for physicians are intensive care units (ICUs) and hospices, where important issues are revealed that deserve serious attention, such as unmourned loss, unrealistic expectations, uncertainty in relating to patients, unasked questions, suffering, and unexplained death. Unmourned loss occurs when caring for critically ill patients who are dying. It is no secret that physicians try to suppress their feelings to maintain their composure and the ability to care for the next patient. However, this accumulation of not talking to anyone or allowing oneself to feel the impact of these experiences often results in an overload of unresolved emotions and sadness from unresolved grief.

In the opinion of Dr. Grim, (2000,322) a specialist in critical care medicine in her book entitled “Just Here Trying To Save Few Lives”, she points out that when an intensive care physician informs a family member of the death of a loved one, I quote: “This is the moment when people hate the doctor. One has failed, one has thrown one's arms in the air, one can be sued, one gives an image of being incapable, and part of oneself believes all this, because no matter how much one has done to save the patient, one always hopes that miracles can be performed.” There are no easy solutions for the suffering of patients, nor for that of doctors, however, we believe that attention, compassion and conversation are important in both contexts. In order to avoid Burnout in vulnerable doctors, respect is required for the stories of doctors, for them to express their anxieties and problems, to resort to therapy methods, and health institutions must allow renewal, self-care, protection, mutual support and reflection, creating conditions of

Optimal, ergonomic workstations that provide programs to reduce stress and improve quality of life, considering all of this not as an option, but as an obligation, since the humanization of medicine depends largely on the humanism of physicians. (Ferreira, 2009, 374)

3.4.-Ethical teaching in medicine and the hidden curriculum

In the opinion of Posner (1998, 37) "...the hidden curriculum is the set of norms, contents, customs, beliefs, symbols and values not explicitly recognized in the official curriculum that is related to the teaching of ethical and moral aspects such as appropriate behavior, respect for differences and responsibility, among others." This learning depends more on what is done and how things are said; its contents are not within the subjects or in the curricula, nor do they have standard specifications, but they support the process of socialization and transmission of attitudes, customs and values. (Uscategui, 2014, 234)

There is currently much debate about how ethics should be taught in medicine. Some propose several courses during undergraduate training to teach how to deal with ethical conflicts, while others argue that it should rely on the hidden curriculum. (Suarez, 2007, p. 113)

Authors such as Olthuis (2003,933) state that "…medical education should be given in a triad of knowledge, skills and personal attitude, but during medical training emphasis is placed on learning knowledge and skills, leaving attitude in the background". However, to practice medicine the physician must have the necessary knowledge and skills, since his main ethical obligation is to be prepared. Based on the above, some authors propose not abandoning the moral training of the physician in a hidden curriculum, which remains behind compared to the other two aspects, but rather focusing on the development of attitudes and behaviors that should belong to the future physician, resuming the teaching of ethics, its inclusion and evaluation within each formal subject, favoring the

discussion of the topics, improving the teacher-student relationship, which instead of generating anxiety and worry should be based on reciprocity, emotional support, interdependence and support for the development of one's own identity, which would greatly facilitate the acquisition of technical-scientific learning and also commit students to always be aware of the importance of this discipline. (Haidet, 2006, 16) 3.5.- Error as a disturbing agent of the medical act.

According to Mc Donald (2000,93) in the USA "…50% of hospitalized patients may be affected at some point by medical errors, in 1999 the Institute of Medicine (IOM) reported between 48,000 to
98,000 (17.26%) deaths annually due to medical errors and adverse events." Some recommendations made by this institute were focused primarily on reducing medical staff fatigue, avoiding nighttime drumbeats, and encouraging rest periods during the workday, estimating that the costs of these measures could be high and their effectiveness unknown.

In this order of ideas, we find factors related to decision-making and inadequate working conditions, with respect to the first we find: limitations of human knowledge due to insufficient professional training that will induce it to make wrong decisions compromising the health or life of a patient. Likewise, poorly applied technological innovation influences incorrect therapeutic indication. Regarding the factors related to inadequate working conditions, many of the failures in the results are caused by the terrible and precarious working conditions of health professionals, these can develop within a perverse, unethical and authoritarian scenario that may seem absurd. Therefore, in Brennan's opinion (2000,1125) "...it is easy to understand what can happen in certain situations."

health institutions where damage and victims multiply, while the easiest course of action is to blame the doctors."

For these reasons, one of the physician's responsibilities must be to report poor working conditions, recording them in the medical history as part of the documentary evidence and also to report them to the competent authorities to demand adequate provision of resources, protected by the Law on the Practice of Medicine (LEM, 2011,12) in its article
25, numeral 5, states: "Report to the competent authorities any unhealthy or unsafe conditions observed in the work environment, as well as those noticed in public or private places, which constitute risks to the health or life of those who attend them."

It is important to remember that the art of healing must be practiced in patient-friendly environments that guarantee and safeguard the patient's privacy, intimacy, medical confidentiality, and, ultimately, all rights. Elective procedures may be omitted in professional practice, while taking care to conduct urgent and emergency procedures with prudence. In Venezuela, economic hardship has dramatically affected the healthcare system, resulting in overcrowding of patients in hospitals. Occasionally, patients have had to be treated on the floor due to a lack of available beds and stretchers, in addition to other resource constraints.

Certainly, in medicine there are medical acts that could cost the life of the patient, among the most notable, are named: treating the wrong patient due to an erroneous identification of the same, leaving surgical instruments inside his body, negligence in the supervision of individuals with dementia or Alzheimer's that allows them to get lost during the course of their hospitalization in the health center and being disoriented and without surveillance suffer an accident or die from hypothermia or dehydration. It is of vital importance to point out the existence of long waiting periods that must

endure the sick before being treated, especially in the case of life-threatening diseases such as bacterial meningitis, myocardial infarction, evolving cerebrovascular accidents, head trauma, peritonitis, acute pancreatitis, emergency surgical interventions, cholecystitis, sepsis, whose delay in care, diagnosis and treatment could lead to lethal consequences.

3.6.-The negativity of accepting therapeutic maneuvers

A wide variety of conflicts often arise in medical practice, including those of a religious nature, such as the refusal to accept a transfusion of blood products when the patient's life is at risk, and the decision involves children or patients whose health is critical, and although there are currently other resources in the therapeutic arsenal such as erythropoietin (a hormone that increases the production of erythrocytes), colloids (intravenous infusion fluids that, due to their composition with albumin or polymers, have the advantage of increasing oncotic pressure) and autotransfusions, many times the indication for a blood product does not admit substitutes when the seriousness of the patient's condition requires it, so the denial of an urgently required transfusion would entail a violation of the right to life and health, leading to death (cases of complicated septicemia with disseminated intravascular coagulation and hypovolemic shock, very serious cases that lead to massive hemorrhages and death in a short time) make the administration of blood imperative. When complaints are filed by religious groups, the CRBV in its article 2 establishes the protection of life as an inalienable legal asset, such that the doctor would be protected when making an urgent decision in a specific case and at a specific time, such as a dying person brought to an emergency room in a state of unconsciousness due to hypovolemic shock without any family member or representative. Similarly, the Organic Law for the Protection of

The LOPNA (Organic Law on the Rights of Children and Adolescents) states that the legal system prevails over the autonomy of the individual, and the physician must act accordingly. The reflection on this constitutional guarantee of the protection of the right to life is that it would contain a duality: while safeguarding that right, it would establish a limitation on the bioethical principle of the patient's autonomy to decide about their health.

3.7.-The aggressive patient

In Latin American countries, one of the most pressing issues is violence in its various forms and manifestations, impacting both individuals and communities. In this regard, healthcare centers are one of the most at-risk workplaces for exposure to aggression because they handle a great deal of activity and emotions related to life, illness, and death. This leads to close interaction between healthcare personnel, family members, and patients, which sometimes triggers situations of conflict and violence. (Di Martino, 2001, 27)

In the psychological context, violence is a type of inappropriate response that arises as a secondary reaction to different emotions due to the lack of appropriate defense mechanisms for that particular situation of frustration, fear, anxiety, or fear of being belittled. All these impressions converge in hospitals, constituting a type of maladaptive response. Its level can range from insults and recriminations to physical attack, and this depends on each particular factor of the patient, their family members, and the environment of the institution. Naturally, if these three areas fail—that is, the self-restraint of the patient and their family members, the ignorance of the physician, and the failings of the hospital—there will be a greater risk of a violent outcome.

Personal factors:

1.- Age: Being young is a risk factor for violence, since at a younger age, there are fewer defense mechanisms in situations

conflicting, likewise, a novice doctor has much less experience in dealing with difficult situations.

2.- Sex: It has been determined that there is a slight predisposition of aggressiveness in the male sex over the female and it is linked to life experiences during childhood, especially with a history of abuse during childhood, the degree of previous successes or failures in life experiences, as well as the adequate coping and channeling of previous grief, the immediacy of reactions and the unflattering physical appearance.

3.- Relationship with the environment: There are factors that promote aggression, such as working alone, without other professionals or people who can notify the authorities of the aggressive situation, working with the public and contact with stressed or anxious individuals, the sense of danger perceived by the aggrieved party, the psychological situation of the actors in the doctor-patient binomial, and the expected and feared consequences, as well as the perception of acquired rights.

4.- Institutional factors: A hostile institutional climate, where there is no guarantee minimum respect for the rights of the patient and workers, as well as the supervision of regulations and surveillance, can serve as scenarios for violence. A hospital that does not provide comfort for both the patient and its workers, lacks a dignified, appropriate and organized waiting environment for the patient and their families, lengthens the waiting time to be seen, among other factors, generates greater tension in the patient and their families, since they do not receive a response to their request for health services. Added to this are the educational, cultural, and political aspects of the facility and its projection to society. Likewise, the personality of both the patient and the doctor is important, with risks for aggressiveness, called temperaments, among the most important for the development of this phenomenon are the

passive-aggressive, paranoid, compulsive, histrionic, borderline, antisocial or dissocial personality, attitudes and expectations.

5.- The patient's clinical condition: There will be a greater risk of aggression in emergency services and in institutions that reward aggression from the public, patients, and their families, and consequently, this attitude serves as a pattern of behavior for all staff to emulate. An associated factor is the shortage of medical materials and supplies for patient care, who channel their frustration and anguish into violence.

6.- Recognition of objectives: The physician must recognize and focus on what is truly important, rethinking the direction and purpose of the doctor-patient relationship.

7.- Self Disclosure: It is described as a technique used in cases where the patient is aggressive from the beginning or it is impossible to reorient the relationship, for which the health personnel tries to show him/her their feelings.

8.- Proposal for a new relationship: Sometimes it is necessary to propose that the patient be treated by another staff member in order to achieve the necessary empathy and trust for the proper functioning of the doctor-patient relationship. However, this option should be used as a last resort and unfortunately is not always possible due to the current lack of doctors in public hospitals.

In the presence of aggressive or stressful work environments, control and prevention measures could be adopted. These measures could range from adequately welcoming the patient, avoiding delays and delays, keeping waiting rooms uncrowded, and, if possible, maintaining a calm and relaxed atmosphere, avoiding arguments, as well as loud tones of voice or shouting. Ideally, the patient should have an initial contact or greeting with the healthcare staff, and it may be useful to train the team.

I work with self-control and coping tools to help them avoid being carried away by negative emotions, using maneuvers such as counting to ten or emotional counterbalancing that imbue the patient with a balanced and peaceful emotional state, avoiding aggression at all times.

9.- Personalization of messages: The patient must be made aware of the importance of their illness, condition or complaint, dedicating the necessary time, showing interest in helping them, reminding them of their rights and bioethical principles. As a general rule, in the initial interview the examiner must always think about and give priority to their personal safety, removing necklaces, earrings, glasses, ties, sharp objects, pencils, fountain pens, injectors, or scalpels before interviewing a patient who is presumed to be potentially aggressive, alerting the health team that will care for the patient, in order to alert them of any need for intervention by security personnel and will never perform an evaluation alone if it is suspected that they may be violent. However, the lack of security personnel at public health centers at night sometimes forces the team of medical residents to handle the situation themselves, often without adequate training from universities or health institutions in this area. Aggression may vary depending on each country's healthcare system, given the diverse factors inherent to both the environment and the patient and the physician.

Violence itself is a dyadic process, that is, the examiner's behavior and preverbal communication elements can induce or avoid it. The physician must speak slowly, showing a calm attitude, showing interest in everything the patient reports, without ignoring or criticizing what is being communicated. Frequently, the violent or

An aggressive patient should never be examined if he or she is armed. In this case, the police or security personnel should be alerted. In general, there are recommendations for dealing with aggressive patients, such as: never turning your back on violent individuals or those who appear to be violent, keeping your hands in view of the person, avoiding sudden or brusque movements, and staying out of the patient's reach. Never attempt to touch them when they are aggressive. Early signs of violence include: speaking more rapidly, raising the tone of voice, using sarcastic language, pacing, refusing to sit down, clenching the jaw, among others. Often, when the patient is agitated or very irascible, it is impossible to reason with them. Specialists in this field maintain that, in the midst of aggression, reasoning should be avoided. (Di Martino, 2001, 27)

3.8.-Obstetric violence

It is generally observed that laws are embraced by the evolution of societies and cultures, thus the term obstetric violence has been coined for certain medical acts whose commission is contemplated in the Organic Law on the Right of Women to a Life Free of Violence, this law contains in Chapter III, Articles 15 and 51 definitions on obstetric violence and its types. Article 15: "Obstetric violence. Obstetric violence is understood as the appropriation of the body and reproductive processes of women by health personnel, which is expressed in dehumanizing treatment, in an abuse of mediation and pathologization of natural processes, bringing with it loss of autonomy and capacity to decide freely about their bodies and sexuality, negatively impacting the quality of life of women."

From the previous article, great subjectivity, exuberance of words, loss of clarity of the rule, favoring multiple interpretations that affect legal security because they encompass many

concepts, attempting to cover many particular and complex aspects of each case, although these would theoretically consider respect for the autonomy of the woman, especially for one who is pregnant, it is evident that the norm could collide with medical freedom to decide based on very precise diagnostic criteria and in an emergency, such as performing a certain procedure, such as a cesarean section, even more, it could create the possibility of conflict between the obstetrician and the pregnant woman, who normally comes in distressed and in pain, conditions not ideal for making the most appropriate personal decision. The autonomy of the patient must always be respected, safeguarding their dignity and rights, but some situations can be complex and people normally lack the precise and specialized knowledge of a doctor.

CHAPTER IV

MEDICAL LIABILITY

In this chapter, we will address professional medical liability, a core issue within the legal framework. Medical practice is considered a technical and specialized activity that must be carried out with a high degree of professionalism, diligence, and in accordance with applicable laws and regulations. In Venezuela, the Medical Practice Law establishes certain guidelines and conditions necessary for the provision of health services and the responsibilities of physicians. This law also establishes the offenses and penalties to which physicians are subject in the event of negligence and medical malpractice.

Medical negligence is defined as the unlawful conduct of a physician who fails to fulfill his or her duty to provide timely, adequate, and efficient medical care, resulting in harm to the patient. In this sense, medical liability can have both criminal and civil consequences.

In Venezuela, criminal liability in cases of medical malpractice is defined in the Penal Code, and in these cases, the doctor may face imprisonment. On the other hand, civil liability may arise from damages caused to the patient and may be subject to a lawsuit seeking compensation for damages.

It is important to note that a medical care contract is an agreement that establishes the obligations and responsibilities of the physician and patient in the healthcare process. In this contract, the physician assumes responsibility for treating the patient with due diligence, information, and care, while the patient assumes responsibility for following medical instructions and paying for the services provided.

Medical liability is a major legal issue where physicians are required to meet high standards of quality and diligence in the provision of healthcare services. To avoid

medical malpractice requires a clear and rigorous legal framework that protects both the patient and the health professional.

4.1.-The medical assistance contract

The nature of the contract governing medical care is generally tacit, unnamed, or sui generis, with the legal relationship between doctor and patient not fitting comfortably into any of the classic forms of civil law. Its characteristics are: intuito personae, bilateral, onerous, consensual, principal, and random. (Martin, 2008, 45)

4.2.-Professional medical liability

In the practice of medicine, errors occasionally occur that can have varying consequences for the patient. Circumstances such as fatigue, stress, distraction, administrative deficiencies, lost medical records, or mixed-up laboratory tests can lead to conditioning factors that typically do not have significant repercussions but can eventually have a significant impact on the patient's quality of life and may even lead to death. (Garay, 2005, 11)

Judges regularly acknowledge that medical professionals can make non-punishable errors, but they should not be considered to be fault, harm, or causal link or determinism.

It is established that:

- When there is harm, without fault, it cannot be called medical malpractice.
- When there is a fault, without any harm, it cannot be called medical malpractice.
- When both the fault and the harm are present, without any causal determinism between them, it cannot be considered medical malpractice. (Arteaga, 1985)

Medical professional liability It includes the obligation to compensate for the harmful consequences of actions or omissions that

are committed in the exercise of the profession, obliging themselves to attend to and respect legal rights such as health, life and human dignity, considering as medical duties the assistance to the patient, clinical history, diagnosis and adequate treatment, information and professional secrecy as essential to good medical practice.

Although there is no specific or distinct liability regime for physicians compared to other legal entities, the ways in which they assume obligations for acts arising from the practice of medicine are the subject of specific study. Failure to fulfill these duties compromises the physician morally and legally, bearing in mind that criminality, unlawfulness, and culpability are the fundamental principles of any crime.

The global rise in medical liability lawsuits is due, among other causes, to progress in the treatment of diseases that were until recently incurable, to the triumphalism with which medical advances are disseminated, leading to the consideration of healing as an absolute right, and to the pursuit of economic benefits through compensation litigation. Furthermore, the gradual cultural change in the way society viewed physicians, whose word and practice were almost unquestionable, was associated with a profound alteration in the structure of the health system and the current evolution of medical care, which has become complex, impersonal, and dehumanized, with the consequent divorce of the parties in the doctor-patient relationship. (Tamayo, 1993, 74)

4.3.-Causal relationship between medical malpractice and medical liability

In most cases where medical negligence was determined, the damage caused was preventable and according to a press release from the World Health Organization (WHO) for the year 2007, one in every

Ten hospitalized patients in Europe were victims of malpractice. Remember that these claims can be filed through civil or criminal proceedings.

(WHO, 2007, 15) In civil proceedings, only that which the plaintiff has defined is judged, that is, in the case where the incorrect use of a technique is being claimed, only evidence must be provided to demonstrate this point and, furthermore, the judge cannot judge beyond whether the appropriate technique was used or not, it being the responsibility of the plaintiff and the counterclaiming defendant to prove the facts about which they are claiming.

The counterclaim is the request that the defendant can make against the plaintiff within the same judicial process to introduce new petitions to the court and request their acquittal. However, and despite what the legal system states, in some special cases such as those in which alleged medical negligence is judged, the laws allow the burden of proof to be reversed, such that it is the medical professional who must prove that they acted with diligence at all times, demonstrating that they duly notified the patient and that they did not fail in any way to provide informed consent.

Socially, the doctor has been considered incapable of making mistakes, and if he does make a mistake, he should be punished to the full extent of the law, since he has caused harm to the life or physical integrity of an individual, which may well be partial or total in cases of death. Therefore, when he performs a medical act, he has a great responsibility, assuming several obligations, where the obligations of means, results and safety are mentioned.

The obligation of means is one in which the debtor is required to undertake or carry out an activity without guaranteeing a result. However, there are those who maintain that he will attempt to achieve it, proceeding diligently in pursuit of said end, that is, he undertakes to apply all his knowledge, use all possible treatments and therapeutic options, inform the patient and his family about the outcome.

diagnosis, prognosis, risks, benefits, complications, recording their actions in the medical history as well as the patient's behavior and treatments until discharge, always trying to obtain the best possible result.

On the contrary, the obligation of results, as defined by Crespo (2013, 20), is that where: "The debtor must obtain the result expected by the creditor; it is not enough that he has done everything possible to achieve it. Ultimately, the debtor organizes and commits to obtaining a result, and therefore the creditor considers the efforts made by the debtor to achieve it irrelevant." It is here that the forensic doctor must analyze each case and determine whether there was a breach of duty of care on the part of the medical professional, as well as estimate the possible damages caused. (Rodriguez, 2004, 23)

It is universally accepted that a medical care contract generates an obligation of means rather than an obligation of results. However, until recently, plastic surgery was considered an exception to this general principle. However, the idea is increasingly gaining ground that this medical specialty also establishes an obligation of means, since it requires the use of photography, laboratory and imaging tests, as well as other diagnostic and treatment techniques. (Kvitko, 2011, 8)

If in contractual liability it was enough for the plaintiff to prove the breach of the obligation, it is important to note that, in the case of an obligation of means, for breach of contract it would not be enough the damage caused to the patient but also to demonstrate not having implemented all the necessary procedures to restore the patient's health, that is, not having acted with all the diligence of a good father of a family, therefore, in the case of an obligation of means, both the damage and the fault must be proven.

In recent years, the notion of the obligation of safety, referring to medical liability, has been developed by French doctrine and jurisprudence, referring in particular to the obligations emanating from both public and private health centers.

Obligations of means and results generally go hand in hand, as in the case of a hospitalized individual, where the hospital assumes the former by ensuring their recovery and preventing them from acquiring new in-hospital illnesses, but also the latter by preventing them from suffering accidents resulting from their hospitalization. As occurs with any obligation of results, proving the damage means demonstrating non-compliance and consequently having the right to compensation for damages, provided that there is no exoneration due to an external cause.

In the opinion of Moreno (2012,30) in his article on “Criminal liability of the doctor”, he points out: “imprudence, negligence or non-intentional fault is common in medicine, since intent, that is, the intention to cause harm, is exceptional in this profession.”

There are situations in the practice of medicine where, upon first knowing the facts, we can have a perspective and immediately consider the existence of probable malpractice. However, upon studying them in detail, peculiarities and important aspects emerge that often make it difficult to establish a causal relationship, and therefore, it is impossible to determine medical liability. (Mantovani, 2008, 167) One of the most frequent and interesting situations is when a person undergoes abdominal surgery and the surgeon forgets to leave gauze in the cavity. Days, months or years may go by and the patient may not present any symptoms, injury or damage to their body. However, some time later, due to another condition, they undergo abdominal examinations or surgery and the gauze is found as a chance finding. In this specific case, there was certainly a breach of duty of care, since a body was left behind.

strange to the patient, however, he did not present any symptoms or harm as a result, and this, in part, is related to the individual capacity for reaction or response of each human being, due to the random nature of the medical act. On the other hand, the conduct caused will be susceptible to being considered culpable only if damage susceptible to reparation has been demonstrated, since, without the existence of elements such as culpability, causal link, or identifiable harm, success in litigation would be very difficult.

In the Journal of the Faculty of Medicine of the National Autonomous University of Mexico (UNAM) in 2010, Dr. Dubón published the following clinical case for forensic discussion: "...This is a 25-year-old female patient who attended the hospital's emergency room, where she reported fever, dysuria, and abdominal pain. A physical examination and laboratory studies were performed, which determined a urinary tract infection. She was hospitalized with treatment of ceftriaxone and metoclopramide. She was discharged the next day with a prescription for cefixime, paracetamol, metoclopramide, and given an appointment in 48 hours. Two days later she was re-evaluated. However, there was no note of said care, only a prescription where she was prescribed cefixime, contumax, and trimebutine. As the symptoms persisted, the patient went back to a private physician, who requested a CT scan that reported an appendiceal abscess. Tubo-ovarian abscess, and she was admitted that same day to another hospital, where an abscessed appendicitis was found during abdominal examination. The surgeon's operative note reported grade III appendicitis, an abscess in the pelvic cavity, and loosening of the small bowel loops, so an abdominal cavity lavage with solution, appendectomy, ileostomy, and distal ileum closure were performed. The follow-up medical notes and evaluations indicate that her progress was satisfactory, and she was discharged days later. (Dubón, 2001)

If we compare this last case with the previous one, examining each element, we observe that in this situation there was damage and complications, due to a misdiagnosis that generated malpractice due to negligence incurred by the medical staff, by not properly diagnosing or treating the pathology, appendicitis, this situation being susceptible to civil compensation, for the loss of earnings and consequential damage caused to the patient.

In their daily work, the medical examiner analyzes a wide range of situations to try to establish a causal relationship between the reported incident and the resulting event, using the information, medical records, and documents gathered. It is important to note that this relationship is often not established, and therefore, it is not possible to establish liability for the alleged perpetrator.

In specific cases of medical liability, it is understood that the physician does not act with the intention of causing harm, but, in many cases, due to a breach of duty of care, he or she may incur situations that lead to a court case. Medical expertise is a key element in determining justice, since the forensic doctor acts as an advisor to the judicial authority, and therefore his or her conclusion regarding a fact may have positive or negative effects on each of the parties involved in a criminal proceeding. (Arboine, 2015, 33)

4.4.-The assessment of guilt in medical malpractice

Generally, the criminal liability of the physician arising from malpractice persists, under the problem that encompasses jointly and severally all health professionals as agents of this malpractice, from institutions, doctors, nurses, assistants and all those who have in some way participated in the care of the injured patient, discerning only the severity of the penalty or economic sanction, according to the degree of participation of the health agents involved in the treatment.

It could be inferred that the role of the physician in modern society seems to become increasingly complex and difficult, as the practice of medicine faces a radically different world with new problems and different solutions. (Pizarro, 2011, 667)

The assessment of fault in medical malpractice crimes is a complex issue that requires a detailed analysis of the facts and circumstances surrounding the case. In medical malpractice crimes, fault refers to the physician's lack of diligence or care in the performance of his or her duties, which may result in harm or injury to the patient. To determine the existence of fault in these cases, various aspects must be evaluated, such as the physician's training and experience, compliance with medical protocols and standards, patient care and follow-up, among others.

It is important to note that medical liability can arise both from the final outcome of an unsatisfactory treatment or medical intervention, and from negligent or reckless conduct by a professional. In other words, it is typically assessed whether the doctor acted with the necessary duty of care based on the specific circumstances of the case.

The legal consequences of medical malpractice offenses may vary depending on the laws and regulations applicable in each country. In some cases, it may result in administrative or civil sanctions for the professional, while in others, it may involve criminal consequences.

That is to say, assessing fault in medical malpractice crimes is a complex matter that requires a detailed analysis of the facts and circumstances of each case. It is essential to evaluate the physician's conduct in the specific context of the medical treatment or intervention, to determine whether the necessary standards and protocols were met to guarantee the patient's safety and well-being.

4.5.-The civil and criminal liability of doctors

It is accepted that civil liability consists of the obligation that falls on a person to repair the damage that he has caused to another, in such a way that this may arise from the professional practice of medicine, thus falling within the scope of the subjective civil liability of the physician on the occasion of his professional activity.

Elements in the civil liability of doctors:

a.-Unlawful act: the damage results from this.

b.-Medical negligence: implies the existence of fault, lack of due care, deviating from all diligence of a good father of a family and implies an action or omission not adjusted to the lex artis due to negligence, imprudence, incompetence or non-compliance.

c.-Damage: impairment of physical, mental or moral health.

d.-Causal link: the damage must be a consequence of the medical error and is of vital importance from the evidentiary point of view.

e.-Legal obligation: both parties, debtor and creditor, are bound, with the debtor party being obligated to comply with a provision of giving, doing or not doing, under the legal and lawful context.

Civil compensation is pecuniary in nature and includes patrimonial damages (loss of earnings and consequential damages) as well as moral or non-patrimonial damages. Loss of earnings or frustrated earnings refers to the benefits the patient lost as a result of the condition caused. Consequential damages are the direct impairment of the patient's health and range from partial disability to death. They involve the valuation of physical damage and everything caused as a result of the harmful medical act (risky medical treatments, inappropriate transfers, lack of rehabilitation, among others).

The unlawful act establishes that whoever intentionally or through fault, merely through negligence or imprudence, causes damage to another will be

obliged to repair it, this damage is the injury that is done to the property or to the person himself and the suffering that is suffered as a consequence of the aggression caused and that causes the impairment to health, therefore, it must be true, current and not have been repaired, affecting the rights of the victim and the claim corresponds to whoever has a legitimate interest, it must really exist and not be hypothetical, as well as current, being an immediate and direct consequence of the failure to comply with the obligation and affecting the protected and protected right of the victim.

A medical care contract must be executed in good faith and obligates not only the patient to comply with the terms of the contract but also to comply with all consequences derived from it according to equity, custom, or the law. Therefore, a patient may enter into a contract with a healthcare institution, with the latter assuming responsibility for the physicians who perform their work there. The physician's negligence would compromise the healthcare establishment, which would be liable for the actions of its employees, as provided in Article 1,191 of the Civil Code (CCV): "Owners, principals, or directors are liable for damage caused by the unlawful acts of their servants and dependents in the performance of the duties in which they have employed them." Furthermore, the victim or their family members would have a right of action against the institution based on the direct objective factor of guarantee. They would not need to prove the physician's negligence in the causal relationship to the damage. They would only need to demonstrate that the institution has caused harm to their health, which must be compensated because it was caused by one of its employees or associates.

The above leads us to infer that a tutor is the person who, having the supervision of the student, imparts a teaching, not an education, therefore, in the training of doctors, tutors are not only those who teach the art of the medical profession, but also, at the level of hospitals or institutions providing health services,

We find ourselves teaching already graduated physicians who are training in a specialized area of medicine.

Likewise, it is important to take into account that in the event of harm caused to a patient during a surgical procedure, the patient or family members, as permitted by law, may sue all members of the team seeking compensation or indemnification for the harm caused. Once the damage is proven, it will be presumed, in each specific case, that there is an immediate causal relationship between the actions of each of the medical members of the team and the final result obtained. This has been established by the CCV in Art. 1,195: "If the unlawful act is attributable to several persons, they shall be jointly and severally liable to repair the damage caused." The victim does not differentiate between the culpability of the employee and that of the principal, owner, or director. There is only one legal entity, which is the institution, in which harm has occurred through one of its members, therefore there is a legal obligation, specific to the Law on the Practice of Medicine, which orders these institutions to provide the security and due confidence in those services that it normally offers, we mention Article 15 LEM: "No medical assistance institution, public or private, may operate without authorization from the Ministry of People's Power with competence in health matters. All institutions dedicated to the provision of medical assistance services shall be governed by the regulations and standards issued by the Ministry of People's Power with competence in health matters. These institutions must have appropriate buildings and environments; trained personnel; adequate materials and supplies; and, in general, the essential elements for the type of services they offer. Rural medical centers must have properly equipped housing for the doctors who provide their services there."

The CCV, states in article 1185 that "Whoever intentionally, or through negligence or imprudence, has caused damage to another, is obliged to

repair it…" Article 1196 of the aforementioned legal instrument provides how these damages must be compensated, including medical expenses for the time in which the patient stopped working, as well as other payments incurred by the injured party or his family to restore his health or rehabilitation, that is, loss of earnings and consequential damages.

Criminal liability in medical malpractice arises from the interest of the State and individuals, interested in maintaining legal harmony and public order, so the sanctions are those imposed by CPV, including: prison, confinement, fine and disqualification, highlighting that every guilty person must necessarily be accountable, but not every accountable or reported person is guilty, finding in the latter the two subtypes of culpability, intent and fault.

In another order of ideas, the willful or intentional crime is one where the unlawful result coincides exactly with the intention of the subject, the agent executes a voluntary and conscious act, typically unlawful, achieving what has been proposed, an example of this would be when the active subject of the crime, has the intention of murdering someone and kills him, but it is evident that in the practice of medicine, there is no intention or purpose in the doctor's animus to harm, harm, injure or kill any of his patients, except in those extreme and rare cases in which the doctor has used his profession to commit a type of intentional crime. In negligent crimes, the final result of the action that causes harm to the victim did not correspond with the final attitude or intention of the active subject of the crime, that is, without the intention of achieving the harmful final result that has occurred.

4.6.-Contractual and extracontractual medical liability

Civil Law establishes two liability regimes: extracontractual or aquilian and contractual, the latter assuming a prior relationship between legal subjects and the breach of an obligation.

pre-existing arising from a contract or other legal form, it being sufficient to prove the breach of the obligation arising from the contract, it is currently widely believed that medical liability is contractual, while in Aquilian liability, the plaintiff must prove the existence of fault. However, a medical act may give rise to simultaneous claims in the contractual and Aquilian spheres, an example of this would be the relatives of a patient who died during medical treatment, who claim in the contractual sphere as heirs for the damage suffered by the person who had entered into a medical care contract with the institution, and in extracontractual proceedings, the harm caused as a result of the fatal outcome, or a patient claims contractual liability against the institution to which he was affiliated and for Aquilian liability against the doctor whom he holds responsible for the damage caused. (Bonilla, 2004, 15)

CHAPTER V

FACTORS HEALTH INSTITUTIONS GENERATING MEDICAL MALPRACTICE

Medical malpractice is a common problem in the healthcare field, and its origins lie in a series of institutional factors that contribute to its creation. In this chapter, we will focus on the different factors involved in medical care and their role in the development of medical malpractice.

One of the main institutional factors that generates medical malpractice is hospital internships. These professionals, who are in training, often face complex situations and very difficult decisions without sufficient experience. Training programs should ensure adequate supervision and support for these physicians, as well as provide them with a safe learning environment that prevents errors and negligence.

Likewise, medical residents and interns, as well as medical students, must also be considered in malpractice prevention. Although they are in a learning process, their participation in medical care entails an ethical and legal responsibility. The supervision of these professionals by more experienced physicians and the incorporation of rigorous clinical protocols and guidelines are essential to avoid errors and ensure proper patient care.

Medical department assistants and heads also play an important role in preventing malpractice. These professionals, due to their experience and leadership, must ensure compliance with quality and safety standards in medical care. Adequate training and supervision of the physicians under their care is essential to ensure ethical and responsible practice.

In addition to medical professionals, public and private health facilities also have a responsibility to prevent malpractice. They must provide adequate resources, both human and technical, to ensure quality care and minimize risks.

of errors. Furthermore, it is essential to have clear policies and procedures that promote patient safety and establish control and monitoring mechanisms.

Regarding liability, both physicians and healthcare facilities must assume the consequences of their actions. In cases of malpractice, those affected have the right to seek compensation for the damages suffered; and the professionals and facilities involved must be sanctioned according to current regulations. It is important to have effective oversight mechanisms that promote transparency and accountability in the healthcare sector.

Specifically, medical malpractice can be caused by a series of institutional factors in the healthcare field. It is essential that medical professionals, both those in training and those with more experience, be aware of their responsibility to prevent errors and negligence. Likewise, healthcare facilities must guarantee adequate conditions and promote policies that ensure quality and safety in medical care.

5.1.-Responsibility of health care establishments

Healthcare facilities are staffed and equipped to provide medical care to society, for the prevention, diagnosis, treatment, and rehabilitation of diseases, functioning as educational settings at the undergraduate and graduate levels. They must have internal regulations defining their organization, staff responsibilities, coordination mechanisms, internal and external communication, procedure manuals, guides, and protocols focused on patient care, staff, supplies, maintenance, and safety. These include responsibilities specific to the healthcare facility, its staff, the emergency service, or outpatient care units and supporting medical services.

In cases of medical malpractice, the institution's liability will coexist with that of the physician, due to the commitment to the patient when providing health-related services. If there is a failure to provide services, this constitutes noncompliance and therefore liability. We must emphasize that hospitals or clinics incur a tacit obligation of safety, as it is not enough to guarantee patients qualified medical professionals; they must also be assured of impeccable medical care, protecting them from unnecessary risks and providing the greatest possible benefits, meeting their corresponding needs. Once the physician's fault is established, the establishment would also bear inexcusable joint liability, unless there is a force majeure situation.

In general, institutional health responsibility has characteristics that are more related to the health activity itself and its complexity than to an a priori legal distinction between contractual or extracontractual, public or private, and is a truly complex issue to elucidate. These characteristics are common to both the public and private health subsystems.

From the perspective of contractual liability, three specific elements are identified: a prior obligation arising from a contract between plaintiff and defendant, breach of the obligation by the debtor, and finally, the breach must be attributable to the obligor. From the non-contractual perspective, it remains to identify the role played by free action or omission and capacity. (Ramos, 2006, p. 151)

Every health establishment is obliged to diligently assist the patient, therefore negligence is inferred from not having complied with the expected standard of conduct, understanding that the lex artis is required of the hospital or clinic twenty-four hours a day, since the patient will always be under its care, while the health provider, the natural person, cannot always remain there, and certain facts of both the patient and

of third parties who care for the patient may be beyond their control. An existing event, but not properly recorded, may be beyond the physician's knowledge, but it will always be within the sphere of control of the health facility, which is required at all times to perform institutional behavior of patient care. (Pierry, 1990, 67)

We illustrate what we are commenting on by reviewing clinical cases of legal interest in Latin America, mentioned by Cárdenas (2011,240) such as the lack of supervision during the night shift on April 16 and the morning shift on April 17, 2002 in a hospital, where the evolution of a complication affecting a newborn after arterial venipuncture is reported, initiating anticoagulant treatment late, considering that the delay in applying it was due to the lack of surveillance of the minor, causing the irreversibility of the ischemic condition with the consequent amputation of his left hand, in effect, the forensic medical report in the judicial process attached in the proceedings without being objected, was clear in specifying that the arterial vasospasm that affected the minor constituted a complication likely to occur in a procedure such as the one practiced, highlighting an inexplicable delay in starting the anticoagulant measures necessary for his treatment and also that the unfavorable evolution, was the one expected for those situations in which it is not started early, which ultimately led to the amputation of the affected limb. In this specific situation, in which a premature newborn presented arterial vasospasm after a puncture necessary for intensive control, with failures in monitoring and surveillance for approximately ten hours and which became complicated to the point of having to amputate the limb, it was inferred that adequate diligence was not taken in the placement of the anticoagulant to reverse the complication that had been experienced, therefore, it was only possible to conclude the lack of service, because the delay

The application of the anticoagulant generated serious consequences that required the amputation of the aforementioned limb.

The reported case alleges institutional negligence due to a lack of diligence or care for a newborn admitted to a neonatal intensive care unit. This situation implicates the responsibility of the healthcare facility, not the physician, as the cause of the injury is not the placement of the catheter in the brachial artery of the left arm at the elbow crease. Indeed, when the vasospasm occurred, the thermal measures indicated in these cases and warming of the limb were applied. The failure, according to the judge who ruled on the case, lay in the lack of care or follow-up during the progression of this complication and the delay in administering the anticoagulant, with no staff at the institution providing care for more than ten hours. In this regard, perhaps a different judicial decision would have been made in Venezuela.

Just as in the operating room, the responsibility generally lies with the surgeon and, indirectly, with the healthcare facility, the nighttime care of hospitalized patients usually entails institutional responsibility. The attending physician is typically not present 24 hours a day and can only be reached by telephone. This requires the vigilance of nursing professionals, assistants, and internal medicine physicians at the facility to notify the attending physician when necessary. Therefore, diligence is required in the institutional care of the patient to assess the situation and act with the trained personnel present, or to call, alert, and request instructions from the attending physician so that he or she can personally attend the facility.

5.1.1.-Health responsibility: The lex artis and the lex praxis.

Lex artis, in the broadest sense, is the correct healthcare practice, both theoretically and practically. The theoretical aspect of the practice refers to decisions that are in accordance with the state of the science. Thus, in medical cases, the literature

specialized recommends proceeding in this or another way, however, at a practical level there are also demands, since the chosen technique to be applied must be executed carefully, this second aspect is known as lex praxis, both the professional and the establishment must not only correctly choose the idea but also provide all the measures to execute it adequately, for this reason, both the lex artis and the lex praxis constitute factors that lead to the conclusion that health liability cannot be considered as an objective responsibility. Although the best known concept is that of lex artis, it can be broad and comprehensive in theory and practice, the division between lex artis and lex praxis better illustrates why fault is not and will not be abandoned in health liability, even if it is public. Indeed, diligence is required at the level of ideas, that is, a correct diagnosis and the choice of the appropriate treatment and at the level of practice, with respect to the careful execution of the treatment, diligence is required on two levels and cannot be dispensed with from the intellectual or practical point of view. (Pierry,1990,67)

5.1.2.-Responsibility of students, medical interns and residents in health establishments

According to Yepes (2003,28) "...it does not seem acceptable that health establishments that accept university students as interns or residents excuse their responsibility by indicating the personal fault of these students, when it is evident that they are in the learning process, that other medical colleagues are teaching them, and that the responsibility, eventually, must be shared between the institution and the professionals who train them. Regarding the provision of anesthesia by medical or paramedical personnel who do not have a specialty in anesthesiology, it was pointed out that such an event compromises the responsibility of the hospital institution.

for the damage caused to the patient, without being able to rule out the personal responsibility of the person who carries out the anesthetic act."

It is well known that inmates will be exposed to emergency situations, both in terms of the severity of the patients' ailments and the necessary speed of action. If their teachers are not present, a harmful outcome is not surprising, especially if the students are halfway through their learning process, creating the dangerous illusion that they are capable of solving all the cases presented to them, since they have already seen or collaborated on other similar situations. Therefore, we believe that the instructions these inmates must receive must be precise and institutionalized, and that it is the duty of the institution to prevent, not to leave them without supervision and support at all times. (Dominguez, 2006, 259)

Since the second half of the 20th century, medicine has been based on medical equipment, More than in the exclusive treatment of the patient with a particular professional, this new collective practice of medicine constitutes a preferred area of liability for the act of another, the latter is traditionally defined as the act by which a person (the civilly liable) must answer for the harmful consequences of the activity of another person (the primary responsible) when he has not committed any fault that can be reproached. Liability for the act of another is therefore a responsibility without one's own fault. (Dominguez, 2018, 159) Currently, health establishments are so intertwined with the services provided that a negligent and harmful act would be exceptional in which the establishment did not have at least a share of its own institutional responsibility, along with a responsibility for another, since there are many edges that call for direct institutional responsibility: the necessary accreditation of professionals, the use of physical facilities, medical or pharmaceutical equipment and supplies, coordination with the

Nursing department, lack of property maintenance, lack of supervision by subordinates, internal disorganization, lack of materials and shelves, drug labeling errors, lack of hygiene, incompetent staff, and equipment failure—these sources of danger only occasionally cause damage that is legally proven. Institutional liability seeks not only to compensate the victim but also to prevent further damage. The legal entity must be aware that it will potentially face institutional civil liability and, therefore, must take preventive measures aimed at reducing harmful events within the health facility.

5.1.3.-Liability for lack, risk or inactivity

In the opinion of Rivero (1984,78) "...the responsibility for the lack or abnormality in the functioning of the health service is justified in the right that all individuals have to obtain a normal and adequate public service, in such a way that, when the administration fails to comply with this obligation, it must compensate the individual, except in cases of force majeure, fault of the victim or the intervention of a third party, provided that the injury is a consequence of the defective or abnormal functioning of the latter."

The following are considered to be cases of liability for the lack or abnormal functioning of the service: material administrative actions, through the provision of public services. These include a whole catalogue of damages that the administration may cause due to defective provision, including those caused by an inefficient health service, with the State being responsible and having to compensate for the damages caused by the poor condition of the facilities. (Badell, 2014, 73)

When the Administration, in the exercise of its mission, creates and exposes some people to a particular risk, liability for damage is generated. In this sense, an activity will be dangerous or risky whenever, with or without instruments, a legal entity, through its activity,

generates more risks of harm than a person is capable of bearing, the disruption of that balance of risks with which nature endowed individuals, requires that the agent of that disruption assume its consequences. (Nieto, 1982, 51)

Establishing liability is reduced to proving the causal relationship, regardless of the fault of the material perpetrator of the damage, which is neither relevant nor necessary for the purposes of determining liability, with the Administration being responsible for the event of fortuitous event. Therefore, even if the perpetrator of the fault cannot be determined, that is, whether it is anonymous or impersonal, the individual is guaranteed compensation, provided the causal relationship is verified, and the Administration can only exonerate itself by proving an external cause (force majeure, the act of a third party, and the fault of the victim). (Faría, 2007, 24)

Fault ceases to be the exclusive protagonist in the scenario of liability for damages, but rather shares it with a new attribution factor, producing a sort of socialization of the obligation to respond, by virtue of the fine-tuning of the attribution factor.

5.1.4.-Theories on the civil liability of public health establishments

Health services are organs of the State administration and are subject, first of all, to the Constitution, by virtue of the principle of supremacy thereof, authors such as Soto (2008,91) consider that the bases of public responsibility are found in the analysis of the situation of the victim as primary data, not in the fault, nor in the guilt or the risk, in such a way that "...the aim is not to sanction the guilty State, but to repair damage caused to a victim in circumstances in which the State was carrying out its functions of common good, the latter being able to have been carried out without negligence on the part of any of its agents, because the victim does not have to suffer damage if he or she is in a situation

completely adequate to the law, and in a legal position that enables it to exercise the right not to be injured."

Some authors maintain that lack of service occurs when state bodies fail to act when they have the duty to do so or when their actions are late or defective, causing harm to the beneficiaries of the respective public service. This does not require identifying the official who caused the lack, but rather committing to invoke and prove the existence of this responsibility in the activity of the state body and that it is the cause of the injury experienced. Therefore, it will be up to the judges to determine whether a conduct is appropriate to an enforceable standard of service.

The distinction between lack of service and lack of personnel has its origins in French Administrative Law, although lack of service was invoked judicially for the first time in France in 1904, it is understood that the public service would be the good father of the family, where Maurice Hauriou, jurist and sociologist, defined it as a violation of the general duty that imposes conducting oneself considering the necessary precautions and displaying all the care required by the activity and according to the circumstances.

In the area of institutional liability, it has been understood that the identification of the responsible person is secondary because it has no legal effect, except in the case of a personal fault or negligence separable from the service. In the medical field, failure to provide service can include multiple situations, such as an abnormal delay in diagnosis or persistent error in diagnosis, poor organization of care, malfunctioning equipment, failure to transmit data to the medical record, failure to monitor or follow up the patient, lack of medical resources, and clumsy handling, among others. (Kemelmajer, 2003, 55)

Lack of service and lack of personnel are part of a classification used in France to resolve conflicts of jurisdiction between administrative and civil justice, considering the existence of lack of service when

the damaging act is impersonal and a conduct was carried out that should not have been carried out, as a result of errors of judgment, inappropriate orders, poor organization or lack of means, among other figures, on the contrary, there is personal fault when the damage is caused by the negligence of a specific person, if the public agent commits it, he must submit to the rules of private law, while in the lack of service, Administrative Law will apply and the administration is responsible, according to Kemelmajer it would mean establishing the immunity of the dependent who acts within the scope of his functions.

In personal misconduct, it is the agent guilty of the damage who must respond with his assets and not the service where he works, these are activities unrelated to the service and that are not justified in the public function performed by the agent of the damage, when we are faced with a personal misconduct, unrelated to the institution, but which causes damage, the victim can only sue the official and not the State body, or the company on which it depends and there must be a significant relationship between the harmful activity of the official and the one he performs, since the State is not responsible for the doctor if he caused the damage, by carrying out an activity not linked to the public service he provided, the jurisprudence must define case by case, which faults are personal and which are service-related. (Pierry, 2002, 149)

Certain legislations have considered that personal misconduct refers to an act outside the professional activity of the doctor and of such gravity that it is outside the normal development of the service, whether public or private; an example of this would be the obstetrician who leaves the delivery room that catches fire, leaving the anesthetized patient without requesting emergency measures, or the surgeon on duty who, without examining a minor, orders the resident doctor to perform an appendectomy in which she dies, or the case of the doctor who, outside the health facility, stops to provide aid to the injured in a traffic accident, since in that case he has not intervened.

on behalf of the establishment, but at his own risk, the removal of the wrong organ despite the surgeon's expressed doubt during the intervention. With only one nurse and no anesthesiologist, he operated on an open humerus fracture. The patient died from bronchoaspiration during the procedure, and the intern, who intervened by delegation in matters beyond his competence, while the attending physician rested. In all these real cases that occurred in France, the individuals were liable, but not the institution. The so-called personal offense has been interpreted differently in different countries. It can be mentioned that in Chile there is jurisprudence of a case where the wrong hip was operated on, and it was the Treasury that was financially liable to the victim. In many similar situations in that country, it has been the health establishment that has been responsible for the interventions of the interns. (Huepe, 2007, 430)

Based on the theory of extracontractual civil liability of the State, assimilating the relationship between the public official and his public body to that of those who have a bond of subordination and dependence, as if the official were under the guardianship of the public body, in the same logic, to the claim for the liability of those under his charge, the health service would have the right to oppose the claim by proving that it used the required surveillance. (Zelaya, 1995, 695)

We point out again that in Latin American countries such as Chile, there is jurisprudence on torts, such as the case of injuries against María de los Ángeles Larraín Prieto, which occurred in 2005, establishing that in the emergency cesarean section performed by the intern doctor there were no elements of guilt, since the expert report clearly showed that the doctor's actions neutralized the risk of death of the patient, safeguarding the legal purpose of protection, which according to the merits of the process, the accused did not receive the supervision and assistance that should have been provided by the responsible obstetrician, who

Not being present at the time, he limited himself to giving instructions by telephone. Furthermore, the neonatologist on duty was also absent, and while a physician who is not sufficiently trained should refrain from intervening when a given situation exceeds his or her personal capabilities, he or she must overcome this duty to refrain, despite the known risk, when the greatest danger is passivity. (Tocornal, 2013, 324).

From the background gathered, it appears as a reasonable hypothesis that, if Dr. Larraín had waited for the presence of the supervising physician before operating, that is, a more qualified professional than her and whose intervention was due, the harmful consequences for the child would have been much greater, taking into account, as a fact of no small importance, that the defendant went to the delivery room as soon as she was called, examined the patient and ordered her transfer to the operating room to perform a cesarean section and that the death of the child occurred several months after the surgical intervention. In the opinion of the Court, it could not be stated with certainty that this unfortunate event is unequivocally traceable to the doctor's performance, without prejudice to the criminal reproach that may be made to the other defendant. In the aforementioned case, the Supreme Court of that country held the health services responsible for the culpable acts of its employees, whom it considers to be under its care. (Calvo, 2007, 659)

Authors such as Phillip Le Tourneau have pointed out that the theory of risk came to light at the end of the 19th century, the basic idea was that any activity that caused a risk to another, made its author responsible for the harm that this could cause, without having to prove the fault as the origin of the damage, however, the risk of a detriment to health is inherent to every patient due to their quality of being mortal, this possibility is not an element provided by the health entity, the hospital manages the risk that every patient carries, doing it well or badly, but bodily vulnerability is a human characteristic that does not necessarily entail damage, since it can be avoided

through the diligence of both the patient and the institution. (Sanhueza, 2017, 235)

However, the criterion adopted in the III Conference on Civil and Commercial Law of La Pampa held in April 1991, in the opinion of Saux (2005,423) was that "...it is not entirely correct to classify medical science as a risky activity, because professional responsibilities are not regulated by virtue of risk, and the explanation is that in medical activity, this is not put into action by the doctors, that is, spontaneously and on their own initiative, but is introduced into the service at the request of the patient, who, with his or her health failing, demands prompt assistance." In the opinion of Zavala (2004,399) "...medical activity does not unleash risk, but - on the contrary - faces it and tries to avoid it, therefore, if the doctor decides to subject a patient to surgery, where he will use extremely dangerous instruments, there is no doubt that he does so to safeguard the health and life of a patient, hence according to this author his actions should not be classified as a risky activity."

5.1.5.-The evaluation of the fact: the health action or omission

According to Barros (2006,1230), the capacity of legal entities to enter into civil obligations not only includes the contractual sphere but also the extracontractual sphere. This attribution is similar to the objective imputation of Criminal Law maintained by Roxin (1997,1072) in the sense that the legal system is not interested in establishing whether an action is the cause of a result in the physical sense, but rather in what cases a certain result can be normatively attributed to a certain human behavior. In this sense, the legal world cannot be explained only from the causal sphere, since there are obscurities that have not been overcome. The issue of whether such an action or omission caused an effect cannot be fully elucidated either in the public or private sphere, or in the area of contractual or extracontractual liability, since with respect to health liability, each act or omission is a separate matter.

each harmful omission is different from another and each person reacts in a particular way.

When you enter a healthcare facility, you legitimately trust that institution, whether public or private, because it is considered to be formally licensed and authorized to operate, to be accountable for its staff, and, among other things, to be diligent in its area of service.

Under the above assumption, people's expectation that an activity will be carried out within the health establishment whose human and material resources promote, protect, recover and rehabilitate the health of patients is valid. This is an institutional trust, therefore it is not necessary to specifically know the natural person who has acted negligently, but rather that the corporate behavior as a whole is proven to be negligent. (Bello, 2009, 310)

The fact that the author is an undetermined natural person, and therefore not identified in the claim, as occurs in claims in other countries, does not render the action indeterminate, since although it is not possible to make a subjective challenge, it is legitimate to objectively attribute the fact to the conduct of the legal person. If the fact is true, the determination of the natural persons involved in it would not be relevant. (García, 2002, 158)

The concept of breach of service, a typical nomenclature of public administration liability, reflects the importance of certainty that the harmful act originated in a public service, but it contains no reference to precisely which natural person committed it. (García, 1997, 469)

5.1.6.-Direct and indirect responsibility of the health establishment

Health activities for the promotion, protection, recovery and rehabilitation of the individual are part of the health context, hence, many times, direct responsibility coexists with indirect responsibility, and very

Probably the judicial cases contain both, it is necessary to consider that the passive legitimized party of the action is both the institution and the professionals or officials involved, therefore, in the opinion of many authors, if the institution is condemned for indirect responsibility, it must first respond to the victim and then repeat, if it deems it so, against the responsible personnel. (Asúa, 2002, 959)

The legal entity, like any legal entity, is not only responsible for its actions, through direct fault, in this case corporate, but also for the actions of its employees. In addition, healthcare activity uses both human resources to provide its services and material resources, for which it must also be responsible to the victim, such as the continuous and periodic maintenance of the equipment used to perform operations, as well as disinfection of hospital areas.

In general, diligence and care are requirements demanded of health establishments, their absence would presume fault, therefore, it is considered that this does not admit graduation, simply the conduct adjusted or not to the lex artis, if it was done there is no fault and if it was not done there will be. (Malhué, 2011) Normally the health activity is carried out through a collective effort and sometimes, it is not possible to attribute a negligent action or omission to a specific person, because the organization itself of the activity has failed, for this reason, there are cases that may escape the scope of responsibility of the natural persons involved, but not of the legal entity that must ensure the correct harmony of the parties and the whole, whether the natural person who acted within the organization is unknown - anonymous fault - or if it is a structural failure or organizational fault. (Vidal, 2005, 757)

Certainly the existing health administration in health centers may have a degree of commitment in that errors occasionally occur, but this does not exonerate the treating physician from individual responsibility,

events due to poor health management are an epidemic of hepatitis in a hospital ward due to contamination of the intravenous solution used as treatment for several patients without changing the needle, thus inoculating them with the hepatitis virus and whose objective was to reduce costs to the hospital, situations like this somehow induce the criminalization and complicity of the doctors in charge of the ward of the health institution as well as the safeguarding of the life and health of the patients in their care, therefore it is important that despite the difficulties, doctors comply with what is established in the LEM by giving notice of the unsanitary conditions of health centers and not becoming accomplices in irregular situations.

It is worth noting that when working conditions make it impossible to provide good medical practice, deficiencies should be reported and workers should refrain from working under these conditions by submitting their resignation. Complaints and complaints should be filed before, not after, problems and incidents arise, in order to prevent them and avoid being complicit in the situation or shifting personal responsibility onto others. According to data from the Venezuelan Conflict Observatory (OVCS), a total of 94 protests demanding the right to health were recorded in May 2018.

CHAPTER VI

JUDICIAL FACTORS AND EVIDENTIAL LIMITATIONS IN MEDICAL MALPRACTICE

Medical malpractice is a complex and highly relevant legal issue. In this chapter, we analyze the judicial factors and evidentiary limitations surrounding this phenomenon, with the aim of shedding light on the approach to medical malpractice offenses and promoting critical reflection on the different perspectives that can influence their resolution.

One of the fundamental aspects to explore is the fraternity and solidarity among members of the medical profession and its potential influence on legal proceedings related to malpractice. On the one hand, this solidarity can be beneficial, as it promotes cooperation and knowledge sharing among healthcare professionals. However, it can also become an obstacle when it comes to reporting cases of medical malpractice, as it can generate reluctance and protectionism, thus preventing the just prosecution of the crimes committed.

Another crucial aspect to consider is the value of medical records as evidence in malpractice cases. This detailed record of medical care provides invaluable information about the patient's history and the procedures performed, which can help establish potential liability and negligence. However, despite its potential as evidence, its proper interpretation and assessment require careful analysis based on expert knowledge.

The autopsy, for its part, is one of the most conclusive pieces of evidence in medical malpractice cases. A detailed and accurate postmortem examination can reveal injuries or improper surgical interventions, allowing the existence of medical negligence to be determined. However, its performance and analysis also present challenges, such as the need for highly trained professionals and the establishment of clear standards and protocols.

An alarming factor addressed in this section is the impunity surrounding medical malpractice crimes. Despite advances in legislation and growing social awareness, these crimes often go unpunished due to the difficulty in obtaining conclusive evidence and the lack of resources and political will to prosecute them. This constitutes a serious violation of victims' rights and public trust in the health system.

Jurisprudence plays a central role in addressing medical malpractice, both in terms of time and space. The evolution of jurisprudence and its adaptation to scientific and technological advances are essential to ensuring adequate and up-to-date justice in this area. Furthermore, transitional justice is presented as an option to consider in cases where there has been a drastic change in the system of government or in the mechanisms of the health system, thus seeking an appropriate and reconciling response.

We analyze mediation and arbitration systems as alternative avenues for resolving medical malpractice cases. These methods can offer less adverse and faster options for resolving conflicts, allowing the parties involved to reach an agreement and thus avoid lengthy and costly court proceedings.

In short, in this section we delve into the complex world of medical malpractice, analyzing the evidentiary limitations and judicial factors surrounding it. We seek to provide a deep and critical view of this issue, inviting reflection and debate on the challenges we face in the pursuit of effective and equitable justice in these cases.

6.1.- Evidentiary limitations in medical malpractice

Medical malpractice investigations present difficulties in obtaining evidence and generally result in a delay in the criminal proceedings.

Spanish jurisprudence indicates that damages caused by medical malpractice are inherent to a civil contractual relationship; most disputes arise for financial compensation. There are many limitations regarding the possibility of achieving an expert assessment with reliable evidentiary value, since the patient's medical history must be seized and clinical information verified, appointing an interconsultant expert, which adds further delay to the process. Subsequently, the expert opinion must be assessed and interpreted by the prosecutor and the judge, thus encountering evidentiary obstacles in aspects such as the lack of technical knowledge on the part of the parties involved, impediment to obtaining clinical records, in addition to the difficulty of identifying the person responsible for the events.

In another order of ideas, the problem of medical malpractice has a high hidden figure, made up of crimes that were never reported or those that, being reported, did not result in a conviction, due to the difficulty of proof, and that Cordero (1996,408) "...this obstacle in demonstration is one of the most important causes of the black figure in this crime, the origin of which is in the medical act itself and the damage that is generated, since the object of the crime is changing and the injury caused may not be evident at a certain time for the offended person, becoming apparent only with the passage of time, causing the evidence of the crime to disappear or become distorted." Furthermore, expert assessment also faces difficulties, including co-responsibility, solidarity, management, group decision-making, and emotional ties within the medical profession that could impede the process of identifying the person and the exact moment in which the event occurred, generating, according to some authors, a phenomenon of protection among doctors. In addition to the above and according to previous research, there would be

little education, research and culture in addressing this issue, compared to other nations.

Another important aspect of the evidentiary task is the technical nature of the crime, since the medical expert examination is complex and requires extensive analysis by forensic science specialists. This may, in turn, require the assistance of other interconsultant experts specialized in medical disciplines that the Forensic Science Corps does not have, or there are no experts with sufficient knowledge. This delays the outcome of the expert reports that will determine the existence or absence of malpractice and, consequently, the configuration of the objective and subjective elements of the crime. Thus, in practice, the investigative phase would present, to a greater or lesser extent, numerous obstacles in all criminal offenses, a specific technical complexity, but in the case of medicine, it would take on special relevance due to the importance of the legal rights protected.

According to Cordero's criteria (1996,408) "There must be many cases in which the doubt that the judge raises regarding an evidentiary analysis of the medical situation, which is so difficult to assess, is the point that finally decides the controversy in favor of the doctor." This same author points out that specialized knowledge in the matter is needed, both on the part of the judge and the representatives of the Public Prosecutor's Office and the defense attorney, in order to be able to elucidate the existence of a causal link between the harmful result and the conduct of the accused person, which was due to the non-observance of the lex artis.

The medical history is one of the elements that allows us to know the real truth of the facts, but even this offers the difficulty because many people have access to it, that is, doctors, nurses, consultants and medical students, among others, and it may be the case that it is altered, either by carelessness, disorder, or by criminal conduct of

any official of the medical center with the intention of favoring or harming the perpetrator of the malpractice.

6.1.1.-Fraternity and solidarity among medical professionals The bonds of fraternity have historically framed medical practice, a product of the oaths and international codes of ethics inherent to this profession. However, this could raise suspicions of complicity among members of this profession when resolving a medical malpractice lawsuit.

Solidarity has its origin in the word solidus, which means "in solidarity." It is the circumstantial adherence to the cause or enterprise of others, which implies a commitment assumed jointly by several people who are obligated to respond to each other's needs. Solidarity is one of the human values par excellence, understood as a collaboration between people that keeps human beings united at all times, especially when experiencing difficult experiences. The value of solidarity is manifested in recognizing the common good, the sense of a successful life for all based on the moral principles of rectitude, peace, and trust. Applying the above to medical practice, upon recognizing the existence of an erroneous procedure or result and the presence of any of the elements of guilt, or the complications derived from it, whether by action or omission, the hospital's Bioethics Committee should be notified and a medical board requested in order to find a definitive solution for the patient. Otherwise, hiding the truth can have various purposes and lead to multiple consequences. It is not correct to deceive, lie or omit a diagnosis to the patient, no matter how serious the pathology is. Hiding the truth can break the trust placed in the doctor and undermine the autonomy of the patient, who will lose faith in their cure, because they need to be spoken to honestly, since the disease decreases their self-esteem and many times they themselves must carry burdensome questions that require

of exact answers. The physician must ask himself whether his conduct will be in accordance with ethical rules. There are circumstances, such as revealing a harsh truth in the context of health, that require great compassion, sensitivity, empathy, and a commitment to accompany the patient after revealing it. In general, the patient always wants to know the truth about his health, and although he may occasionally experience denial when receiving news of a death, this does not mean that he would prefer to ignore it or that he does not care; he needs to know the reality even when informed of a serious illness. It would be wrong to assume that irrationality and superficiality are preferred. News of a death is a shock and causes great pain, but strength and courage can be drawn from the truth, even when it concerns one's own death.

According to the previous approach, keeping silent and not trying to remedy the damage caused by another doctor would be interpreted as complicity, because the attitude that the doctor must fully assume is a critical position in this regard, not meaning contempt, discredit or defamation of his colleague, because at this point the fact itself is distorted, always trying to prevail the duty to watch over the health of the patient by repairing any damage caused and seeking solutions together, otherwise there is a sin of omission, by not giving notice of a situation that harms the legal asset of the patient such as his health as indicated by the International Code of Medical Ethics of the World Medical Assembly.

6.1.2.-The beneficial or harmful union solidarity of doctors

Depending on the perspective viewed, medical union solidarity could be seen as an advantage or disadvantage in the spread of medical malpractice. On the one hand, solidarity, as a form of protection and support among colleagues, would result in better patient care and a reduction in errors. However, it could also be a form of mutual cover-up and protection in cases of negligence or medical malpractice.

First, it is important to highlight that guild solidarity among physicians can be viewed positively when their efforts result in improved quality of patient care. Communication and collaboration among medical team members increase the effectiveness and efficiency of treatment. For example, when a physician is faced with a difficult case, they can turn to colleagues or specialists for a second opinion to ensure they are making the best decisions for the patient. Furthermore, solidarity among physicians can also increase each physician's personal accountability. When they feel part of a group and know that other physicians depend on their work, professionals feel more motivated and committed, which can lead to better care. to the patient.

On the other hand, there is a risk that this solidarity among medical professionals could become an obstacle to identifying and remedying wrongdoing. If a doctor commits medical malpractice, he or she may be tempted to cover it up in order to avoid public criticism. This attitude can not only negatively affect the patient's health but can also damage the reputation and credibility of the medical profession as a whole.

Medical union solidarity could be a powerful tool for improving the quality of patient care and the accountability of healthcare professionals, but it can also lead to cover-ups and medical malpractice. It is important that solidarity be combined with a culture of transparency, honesty, integrity, and accountability to ensure that the harm caused is identified and repaired in a timely manner.

6.1.3.-Solidarity and medical complicity

	Medical solidarity	Medical complicity
Notion	Responsible commitment to an act or event. Unity and mutual support among physicians to defend their rights and interests. professionals	Participation of the doctor with other persons in the commission of a crime or collaboration in it without taking part in its physical execution.
Basis	The purpose of solidarity is generally positive; this term is often associated with a well-intentioned, charitable, or generous act.	Participation or assistance, active or passive, by doctors in illegal activities related to their profession.
Example	Conduct activities in healthcare centers to improve the mood of patients and their families or provide financial support for medications and travel.	Covering up medical errors or engaging in fraudulent practices.

Source: Own creation.

6.1.4.-The conspiracy of the medical silence

Medical malpractice litigation has been on the rise in the United States, and one of the related factors has been the shortage of physicians, because it has been described that this insufficiency would add an extra element of danger to an already poor health situation, all of this associated with overwork, a high workload, and inadequate or nonexistent treatments. (Kelner, 1970, 5)

A few years ago, the Boston University Medical Research Institute in the United States surveyed 214 physicians, asking them point-blank: "Would you be willing to testify in the Supreme Court if a surgeon, operating on a kidney problem and supposedly removing the diseased kidney, instead removed the healthy one?" At that time, only 31% of specialists and 27% of general practitioners said they would be willing to do so. It is believed that the negligent doctor or hospital would provide safer care if lapses in quality of service and careless acts were not hidden. (Kelner, 1970, 5)

The Hippocratic Oath could serve as a philosophical foundation for the conspiracy of silence, since this statement states: "In whatever house I enter, I will go for the benefit of the sick, abstaining from all evil or corruption and especially from any act of seduction, of man or woman, bonded or free. About the things I see or hear about life

of men, in my care of the sick or even apart from them, who must not be ignored abroad, I will remain silent." The above stated obliges the doctor to not divulge confidential information of the patient, silence is intended to protect the privacy of the latter, but somehow over time it has been turned around to also protect doctors as a sanctuary of immunity in cases of errors and negligence, without having any connection with the therapeutic privilege in the doctor-patient relationship, functioning not only to protect the secrets of the patients, but to hide secrets from them.

In countries like the United States, Puerto Rico, Mexico, Italy and others, there are the so-called "Good Samaritan Laws" whose name derives from the biblical parable granting immunity to doctors for negligence in first aid treatment, because the American Medical Association considered that doctors needed and deserved to be acquitted in these cases, it is considered a legal protection for those who choose to serve and care for those who are injured or sick, its purpose being to prevent people from hesitating to help a stranger in need, for fear of legal repercussions if any error in assistance occurs, these rules already exist in countries like the United States, Canada, Germany, Finland or Israel, also the 911 Good Samaritan Law that encourages people to call this number when they experience or witness a case of drug or alcohol overdose, by granting limited immunity that frees them from criminal charges or prosecution for possession of narcotics (up to 8 oz.), marijuana (any amount) or alcohol. (Kelner,1970,5)

In New York, the Court of Appeals ruled that in malpractice cases, the defendant doctor himself may be required to answer the plaintiff's attorney's questions when a physician is unavailable to testify. Doctors and attorneys in Pima County, Tucson,

Arizona, USA, has taken a major step forward. Many years ago, a medicolegal panel was created, comprised of physicians and lawyers appointed by both the county bar association and the medical society.

The joint panel hears evidence presented by both sides and makes a decision by majority vote on the merits of the case. If there is evidence of negligence, the malpractice insurance company must settle the case. If it does not, the patient is free to litigate the case in court, and the panel cooperates by providing a physician who will testify in court. Otherwise, if the panel decides the case lacks merit, the patient's attorney refrains from suing. This plan has been tested in several states in the U.S., and although it is not perfect, it is a good nonaggression pact that reduces the intensity of the fratricidal war between doctors and lawyers, providing a better opportunity for justice. (Kelner, 1970, 5) 6.1.5.- Medical history as evidence

The clinical history has been defined as the document that contains the ordered and detailed association of all data and knowledge, both remote and current, personal and family related to a patient and serves as a basis for arriving at a diagnosis, it is a way of recording the medical act and its preparation must demonstrate professionalism, since only the doctor can carry it out, its ultimate goal being to help the patient, it has the element of legality and typical execution according to the standards of excellence despite the limitations of time, place and environment. (Guzman, 2012, 15) It must be done clearly and legibly, avoiding blots and the use of Tipex® correction fluid, each note must have the date, time, name, signature of the person responsible, ID and registration number, each beginning or footer of the page must record the identity of the patient and the identification of the establishment, service, bed number, diagnoses must be placed using terms currently used in the scientific literature, which will be tabulated or coded according to the International Classification of Diseases (ICD) of the Organization

World Health Organization (WHO) or the classification adopted by the Ministry of Health. In all healthcare institutions, patient care in their various areas must be recorded in a medical record, ensuring the security and confidentiality of personal data, identifying and safeguarding them, maintaining backups, considering that the minimum retention period is fifteen years, starting from the last care provided to the patient, and providing a report of this action upon request by the patient or their representative.

In the history, extremely intimate data are recorded, leaving a record of the procedures performed, the complications suffered and monetary costs, being useful to demonstrate the medical-hospital diligence, but if it is deficient and does not reflect all the circumstances to reconstruct the clinical picture of the patient, it would constitute a presumption against the doctor, because it reflects the interest, knowledge and dedication of the health team, and one or more individuals who record their opinions and decisions may participate, we consider it relevant to point out the importance of the veracity of the data contained therein since everything recorded therein may be used for or against the doctor, therefore, lightness in its preparation entails professional and personal responsibility.

We find means of testimonial, documentary and expert evidence, where, from the medical-legal point of view, the latter two gain importance, the medical record being the main means of evidence in trials for medical liability, and its incorporation into the file is usually the first gesture of the judge upon coming into contact with the written claim, its probative value lies in the fact that it was prepared for an essentially healthcare purpose, and generally, well in advance of the case arriving in court, on the other hand, the fact of being a document prepared

On the one hand, according to some authors, it gives the character of an anticipated and written confession. (Lorenzetti, 2005, 509)

It has been established that anything not recorded in the medical record is equivalent to something not performed by the physician, and the contrary can be proven by other means, which in fact is often difficult. According to the above, its correct preparation is vital in order to safeguard medical liability. It is important to mention that any physician may be called to perform an expert opinion in a medical liability case, understanding expert evidence as a reasoned opinion of a person specialized in branches of knowledge that the judge is not obligated to know, and that, unlike testimony, it refers to facts perceived sensorially by the person providing it and who must give the version as perceived by Tkaczuk. Tkaczuk emphasizes that the more technical the matter submitted to judicial decision, the greater the importance of expert evidence. Hence, this is one of the decisive means of evidence in medical liability trials. Due to the technical nature of the medical act, the opinion of the experts is fundamental. While not binding on the judge, they will require due justification for deviating from their own conclusions. (Tkaczuk,1994,93)

6.1.6.-The autopsy

Autopsies are an important evidentiary tool in cases of medical malpractice, but unfortunately, they are increasingly falling into disuse today, being replaced in some countries by virtuopsia, a virtual exploration technique that can detect oversights or errors in diagnosis. In the United States, in the 1970s, only 20% of corpses were autopsied and today it is estimated that only 8.5% are. (Burgesser, 2011, 11) Perhaps the reasons are that autopsies often reveal medical errors, leaving professionals and hospitals exposed. On the other hand, for the relatives of the deceased and those close to the deceased, the idea of the body of their loved one being dissected is unpleasant and

Even some religions such as Judaism and Islam reject this procedure, which is why science has turned to virtual autopsies and postmortem imaging as a routine procedure in the US, Australia, the United Kingdom and Japan. (Hull, 2007, 342)

To this end, studies have been conducted on patients who have died in emergency departments. When autopsies were performed on these bodies, diagnoses were found that had not even been suspected, such as malignant tumors and hemorrhagic pancreatitis. In almost half of the cases, there was a significant discrepancy between the autopsy report and the clinical diagnosis. Research at the Private Hospital of Córdoba in Argentina reviewed 53 autopsies of adult clinical cases from January 2005 to June 2009, applying the Goldman classification to establish clinical-pathological discrepancies between pre- and postmortem diagnoses. The most frequent clinical diagnoses were respiratory infections and acute pulmonary thromboembolism, while autopsy findings generally found respiratory infections and acute myocardial infarction, 17 major discrepancies and 30 concordances were detected, respiratory infections occupied the first cause of error, followed by acute myocardial infarction, being the first ones who constituted the main type of error, so in this study it was suggested to adopt informative and educational strategies to revalue the autopsy and traditional clinical practices. (Burgesser, 2011, 11)

The following table explains the major, minor and concordant discrepancies:

Major discrepancies
Class I: Major diagnostic discrepancies. Knowledge of the diagnosis before death could have contributed to changes in management that could have prolonged the patient's life or cured the patient. **Class II**: Major diagnostic discrepancies whose detection before death would probably not have changed survival even with the correct treatment.
Minor discrepancies
Class III: Discrepancies in minor diagnoses not directly related to the cause of death, but with symptoms that should have been treated and that could eventually affect the prognosis. **Class IV**: Discrepancies in minor hidden diagnoses (not diagnosable) but with genetic or epidemiological implications.
Concordances (no discrepancies)
Class V: Agreement between diagnoses.

Source: Bürgesser, with own modifications.

Recent studies have shown that approximately 25% of diagnoses of cause of death are incorrect and are subsequently verified through autopsies, whose significant utility is that it helps correct a large proportion of death certificate errors. Comparing clinical diagnostic studies with the results of autopsies performed in Spain, 52.1% were found to be errors in medical death certificates issued by autopsy and 24% in hospital certificates based solely on clinical criteria. This rate of inconsistency between clinical diagnosis and autopsy findings has remained constant for more than 30 years, despite scientific advances. Of all medical errors, diagnostic errors comprise a substantial and costly fraction. In the Venezuelan context, epidemiological bulletins with figures on concordances and discrepancies in autopsies are currently unavailable.

6.1.7.-Impunity and medical malpractice

Medical malpractice is a widespread problem throughout the world, no country in the world is exempt from it, and it is fundamentally referred to the negligence, imprudence, incompetence or non-compliance of medical professionals in the diagnosis, treatment or surgical procedures of a patient, which can cause serious physical and emotional damage and, in some cases, can even be fatal. Despite the seriousness of this

Problem: In many countries, medical malpractice goes unpunished due to impunity, which has devastating consequences for patients and their families. Impunity, or lack of punishment, could be both de facto (inappropriate functioning of the administration of justice due to internal causes, such as the lack of impartiality of judges, or external causes, such as obstruction of its action by other public authorities or threats from third parties) and de jure (legal norms that impede or limit investigation, criminal prosecution, or the enforcement of judicial decisions).

Impunity, in our study, refers to the lack of accountability and punishment for medical professionals who commit malpractice. Perhaps one of the causes of impunity is the lack of a reliable system to investigate and prosecute cases of this type of crime. The reasons for impunity in the vast majority of Latin American countries are diverse, including weak, slow, and inefficient judicial systems, corruption, and a lack of qualified personnel and financial resources, among others. In some cases, existing legal frameworks for addressing medical malpractice are outdated or inadequate to meet the standards of modern medical practice. Furthermore, corruption is also prevalent in many countries, which can result in those involved bribing government officials to overlook cases in which they are implicated, a situation that further exacerbates impunity. Another critical factor is the lack of awareness among patients about their rights and the legal remedies available to them in cases of medical malpractice. Patients in Latin America often lack the education and legal literacy necessary to navigate the legal system and properly formulate their complaints. (Bonet and Alija, 2009, p. 90)

In Latin America, malpractice lawsuits take two to three times longer than in countries like the United States and Canada. In some cases, due to the lengthy process, the statute of limitations can expire, leaving victims with little recourse. Furthermore, the cost of litigation can often be prohibitive for some victims who lack the basic financial resources to hire attorneys and fund the entire investigation process. Medical malpractice is a serious problem in Latin American countries, and impunity further perpetuates the problem. It is imperative that governments take steps to combat impunity, such as providing education on patients' rights, implementing modern medical practice standards, and imposing severe sanctions on medical professionals involved in negligence. Only then can patients and affected families receive the justice they deserve, and physicians be held accountable for their actions. Creating a dispute resolution mechanism prior to the actual judicial stage could allow the parties to find a solution.

6.2.-The temporal and spatial scope of jurisprudence in malpractice

Jurisprudence is a central term in the world of law and justice, referring to the decisions made by courts and their application in similar cases within a given time and place. In other words, jurisprudence is the interpretation and application of law by the courts, which subsequently becomes a rule or precedent for future cases. The temporal scope of jurisprudence refers to the moment in which the court's decision is issued and the rule is established for future cases. This rule is valid until changed or modified by a new decision; that is, jurisprudence has a limited duration and is constantly updated as new judicial decisions are issued.Regarding the provenance of jurisprudence, only rulings from the hierarchically higher Court are created.

On the other hand, the spatial scope of jurisprudence refers to the territory in which a rule of law established by a court is applicable. For example, a judicial decision issued in a specific country will be applicable only within that geographical area, and not necessarily in other countries. Therefore, jurisprudence has a territorial limitation that determines its application in a specific location.

Regarding its importance, case law is fundamental to the legal and judicial system, as it allows for the resolution of specific problems and the formation of general principles for practical application. In other words, it not only focuses on resolving a specific case but also impacts how the law is interpreted and applied in society. Furthermore, case law is a key factor in promoting justice and equality before the law. Through case law, clear and equitable legal standards can be established to guide the actions of the parties involved in a judicial process, and it is important for ensuring consistency and predictability within the legal system. (Falcon, 2010, p. 115)

There are several limitations in the temporal and spatial scope of case law on medical malpractice decisions, including:

1. Time Limitations: Medical malpractice decisions are based on current medical knowledge and standards, so a decision made several years ago may not be applicable today. Furthermore, laws and regulations can change over time, which may cause previous decisions to be invalidated or re-evaluated.
2. Geographic Limitations: Medical malpractice decisions may vary depending on the country or region in which the event occurred, as medical norms and standards are not always universal, and the resources available to enforce regulations and punish violators may also vary by location.

3. Cultural Limitations: Medical malpractice decisions can be affected by cultural differences and perceptions of medical care. For example, some cultures may have different expectations about pain and suffering, which can influence the assessment of the quality of medical care received.

6.3.-Transitional justice and medical malpractice

Considering that transitional justice can be defined in very simple terms as the set of decisions and mechanisms designed to deliver justice in association with a process of political change, it must be noted that its development has as its priority objective to offer solutions appropriate to the changing social reality in order to demand accountability and offer fair reparation to the victims, with respect to large-scale abuses perpetrated during a previous armed conflict, including the socio-political context in which it occurred, as a consequence of the repression exercised by the regime whose extinction and replacement are intended or have already been carried out, or as a result of the dynamics of action/repression present in a democratic State in which internal tensions or the presence of terrorist groups led in the past to the presence of an intense level of violence and political and institutional instability. Transitional justice, given its implications, must not only be a model of application of justice conditioned by the particular existing factual circumstances, but also a contribution to the solution of the problems of a society in transition and to the objectives of the transition process; It is not strange, therefore, that in its analysis and assessment concepts are used that are not always strictly legal, among them, for example, references to political needs, justice – in an ethical sense of the term –, reparation and recognition of victims, forgiveness and reconciliation, the right to know or to the truth, or historical memory.

Furthermore, transitional justice is, in itself, a process that develops over a more or less prolonged period of time: it is, therefore, a process within another process—that of political transition. Thus, political demands condition both the decisions and mechanisms of transitional justice adopted and their actual and effective functioning. However, logically, the transitional justice policy followed is also a factor that influences the development of the process of political change itself. Transitional justice is, therefore, a delicate process, subject to the pressure of ensuring that the measures adopted guarantee a balance of interests acceptable to society as a whole. Assuming that transitional justice is articulated through legal measures, it must be taken into account that these are precisely the result of a political decision that must be adopted by the authorities leading the transitional process and that they must face, such is their responsibility, weighing all the components described. (Bonet and Alija, 2009, 56) And, that public international law has developed, especially since World War II, a range of legal norms whose compliance by the State could, hypothetically, call into question its transitional justice policy: if the abuses that must be addressed are mainly related to the violation of human rights, whether in times of peace or armed conflict, the international legal system raises legal requirements related to the need to avoid impunity for their alleged perpetrators and to guarantee the rights of the victims of such acts that must be weighed in order to calibrate the legal suitability of transitional justice decisions. Likewise, in this context, it must be remembered that public international law has tended in recent decades, de lege data and de lege ferenda, to strengthen the legal position of the victims of such abuses.

In the context of medical malpractice, transitional justice becomes a complex challenge due to the difficulty in identifying those responsible, who can often be doctors, nurses, hospitals, and the healthcare system in general. Furthermore, medical professionals are often expected to maintain professional confidentiality, making it even more difficult to determine who is responsible for the act. However, transitional justice is essential to promoting trust in the healthcare system and ensuring that victims receive adequate reparation. This may involve the creation of truth and reconciliation commissions, the implementation of regulations and quality control measures in healthcare, and the training of medical professionals in ethics and accountability, which are essential to ensuring quality care.

6.4.-Mediation, arbitration and reparation agreements in medical malpractice

Conflicts arising from defective healthcare have traditionally been addressed through the judicial system, and the advantages of so-called ADR (alternative dispute resolution) for resolving conflicts arising from medical malpractice are evident. Resolution through alternative instruments can significantly reduce bureaucratic, judicial, and management costs, as well as the amount of compensation, which is usually lower than what could hypothetically be obtained in court. Similarly, we believe that the application of ADR to healthcare conflicts improves and favors the clinical relationship and, ultimately, allows for the adoption of a solution that avoids traditional blame parameters, contributing to the elimination of defensive medicine practices. This latest trend, which we can describe as the "flight away from blame," has been progressively established in healthcare-advanced countries such as Sweden, New Zealand, Denmark, Finland, Norway, and the United States, where a no-fault liability system has been applied, under different formulas and variants. For all these reasons, extrajudicial systems have

Establishing itself in comparative health law as a particularly suitable alternative for resolving conflicts arising from medical malpractice: they are fast, economical and effective.

Mediation, out-of-court settlement, and arbitration are three options for resolving medical malpractice disputes that will not require a trial. Mediation is a purely exploratory negotiation process in which a neutral third party, the mediator, helps the parties reach a voluntary agreement. It is non-binding, meaning the parties are not required to reach an agreement. It is a less expensive and faster option than a traditional trial and can help preserve the relationship between the doctor and the patient. Out-of-court settlement is a device in which the parties reach an agreement without the intervention of a neutral third party. This type of resolution can be achieved through negotiations between lawyers. It is an alternative to bypassing the judicial system. of these problems through the conciliation of an agreement with the help of an impartial and independent person, trying to avoid the judicialization of the conflict, it may or may not be binding, creating spaces for dialogue, which helps understanding between both parties, saving costs and decreasing the time in its conclusion. (Cayón de las Cuevas, 2010, 183)

Arbitration is a process in which the parties hire a neutral arbitrator to make a binding decision on a dispute,Arbitration would constitute the most refined form of heterocomposition in that the resolution of the conflict is imposed on the parties through an award that produces res judicata effects and constitutes an enforceable title with the same effectiveness as a judgment.Similar to a trial, but less formal and faster, decisions made in arbitration are final and binding on both parties. Arbitration may be a more expensive option than mediation or out-of-court settlement, but it can be faster and have less impact on the physician's reputation. In each of these cases, it is

It is important to obtain the advice of an experienced medical malpractice attorney before making any decisions.

We can find various advantages and differences between penal reparation agreements and extrajudicial dispute resolution procedures. Although it seems obvious to mention it, in terms of scope, reparation agreements apply to the penal sphere, while extrajudicial procedures could cover both the civil and criminal spheres, depending on the legislation of the country.

We found that, in terms of the type of crime, reparation agreements are used in criminal offenses, conduct classified and punished by criminal law. They are a way for the accused and the victim to reach an agreement to repair the damages caused, without the need for a criminal trial to conclude. On the other hand, civil remedies for extrajudicial reparation are a way for the parties to reach a compensation agreement without having to resort to a civil trial. These include breach of contract, medical negligence, and product liability, among others.

From the participants' perspective, reparation agreements involve only the perpetrator and the victim, while extrajudicial means may involve a mediator, conciliator, or arbitrator.

Regarding purposes, reparative agreements seek to repair the harm caused by the crime, while extrajudicial remedies aim to prevent and resolve conflicts. From a legal perspective, reparative agreements have binding legal effects, while extrajudicial remedies may or may not have binding effects if they are not reflected in a legal agreement. There are also differences in exceptionality, as reparative agreements are exceptional and can only be applied in specific cases, while extrajudicial remedies are more commonly used. Furthermore, with respect to advertising,

Reparation agreements are confidential and not made public, while out-of-court remedies may be made public if the parties agree. Regarding binding force, reparation agreements are mandatory once accepted, while out-of-court remedies may be voluntary.

Advantages of criminal reparation agreements	**Advantages of extrajudicial dispute resolution**
1. They allow for a quick and agile solution to the conflict. 2. They help repair the damage caused to the victim. 3. They avoid the execution of a sentence. 4. They promote dialogue between the parties. 5. They improve the perception of the justice system. 6. They are a less expensive alternative to a criminal trial. 7. They can be more satisfactory for both parties. 8. They help prevent the collapse of the justice system. 9. They promote mediation between the parties. 10. They are a tool for social pacification.	1. They are a more flexible and less formal alternative to the judicial system. 2. They allow for a faster and more effective solution to the conflict. 3. They promote communication between the parties. 4. They can avoid public exposure of the conflict. 5. They are a less expensive means than a lawsuit. 6. They are more informal and less stressful options than a trial. 7. They can be more satisfactory for both parties. 8. They help avoid congestion in the courts. 9. They are more respectful of the rights and needs of the parties. 10. They are better adapted to the needs and circumstances of the parties.

Disadvantages of reparation agreements penalties	**Disadvantages of extrajudicial means of conflict resolution**
1. Some cases cannot be resolved through reparatory agreements. 2. They can perpetuate impunity in some cases. 3. Depending on the severity of the crime, it may be difficult to reach a fair settlement. 4. They may be less effective if the victim is unwilling to participate. 5. They can be seen as a less fair solution for the perpetrator of the crime. 6. They are not suitable for cases where either the victim or the accused cannot negotiate. 7. They can generate a sense of injustice in society. 8. They cannot solve all problems with the same efficiency and equity. 9. Lack of knowledge and skill among negotiators can affect the results. 10. They can be seen as a form of pressure to get the victim to accept a solution.	1. Decisions made by mediators may not be binding in themselves. 2. Lack of applicability can make solutions less effective. 3. The lack of experience of mediators or arbitrators can lead to an unfair outcome. 4. They may not be suitable for complex and delicate cases. 5. The solutions may not be fair enough for the parties. 6. The weaker party's lack of knowledge and skills can affect the outcome. 7. The parties may feel that they are being forced to reach an agreement. 8. They can perpetuate the imbalance in power between the parties. 9. They can generate a feeling of helplessness among the less favored parties. 10. They may be less suitable for cases where justice must be applied more rigorously.

Source: Own creation

6.5.-Exemptions from medical liability

The existence of various circumstances that may release a physician from contractual liability is generally accepted. These include excusable error, necessity, and external causes (force majeure, the patient's conduct, and acts of third parties). Excusable error or medical error itself, which is not accompanied by fault, is an exemption from liability. A fortuitous event is understood to be anything that could not have been foreseen or that, even though it was foreseen, could not have been avoided. Essential characteristics include unforeseeability and, especially, inevitability. There are cases in which the patient's own conduct exempts the physician from liability. These are cases of harm caused by the patient's refusal to receive blood products, abandonment of treatment, or consultation with a new medical professional. These circumstances imply the patient's breach of the medical care contract, and the physician will not be liable when the harmful result is due to the intervention of third parties. These situations, referred to in civil law as acts of the victim and acts of third parties, determine the lack of the essential causal relationship between the medical act and the harm.

The lack of valid, freely expressed, sufficiently informed consent, granted by a civilly capable person prior to the medical act, constitutes a hypothesis of liability in case of damage caused by the medical act, however, the state of necessity empowers and even obliges the doctor to act, it is classic to point out that in the presence of certain danger to a greater legal asset such as life, the doctor can act without the express consent of the patient, although bioethics and legal doctrine itself increasingly question this approach, gaining ground the autonomy of the patient and the right to decide about his life.

The condemnation of a healthcare institution or a physician to compensate for the damage caused to his patient as a result of the medical act, implies the

Proof of the basic elements of civil liability mentioned above: the existence of the damage, the cause-and-effect relationship with the medical act, and the medical negligence. In contractual circumstances, and once the damage has occurred, the plaintiff must only prove the doctor's or institution's breach of duty, which is equivalent to saying that fault is presumed, and the debtor may only exonerate himself by alleging an external cause not attributable to him. (Tamayo, 1993, 78)

Certainly, a physician who treats a patient acts legally within the limits prescribed by medical science (lex artis), but such practice also entails a series of prerequisites without which it cannot be justified. First, the patient's consent, where possible; second, the provision of the necessary information about the significance of the treatment to the person affected by it by obtaining informed consent, which must fully comply with all its requirements. If these prerequisites are not met, medical-surgical treatment may only be justified in cases of necessity (e.g., when the patient is unconscious or in a coma due to some severe impairment of consciousness and it is impossible to wait for recovery, nor can their relatives be located), and provided it is performed correctly, that is, within the limits of permissible risk and with due diligence. On the other hand, we would find the justifying state of necessity, which arises due to the clash of two legal assets of different value, when the choice is made to sacrifice the asset of lesser value to save the one of greater value; therefore, we say that in these cases it is essential to apply the criterion of weighing assets. But along with this form of necessity, there is another that is merely exculpatory, governed by the principle that different behavior cannot be required and which would occur when the assets in conflict are of equal value.

Both doctrine and jurisprudence conceive it as a situation of conflict between two legal assets, in which the salvation of one of them requires

the sacrifice of the other. This presupposes that the legal right being saved is in imminent danger of being destroyed. This danger must be real and objective, and cannot be merely assumed, with more or less justification, by the person seeking to avoid it.

The state of necessity between goods of equal value thus justifies the conduct of a third party who autonomously decides which of the people in conflict to save: someone who only has a life preserver and finds himself faced with two drowning people acts correctly regardless of which person he chooses to throw him the life preserver; the same applies to a surgeon who must choose, among several patients of equal severity, who to operate on first. To say that in these cases there is only grounds for exclusion of culpability (due to the inability to enforce other conduct) seems ill-advised.

6.6.- Usefulness or uselessness of a law against medical malpractice

From a legal perspective, some authors have suggested that tougher sanctions or penalties against those who commit crimes in the health field could lead to a decrease in the commission of these types of crimes. Hand in hand with this, many countries around the world have proposed legislating against medical malpractice by creating specific legal instruments that regulate their conduct. Incidentally, a doctoral thesis by Bastidas (2014, 214), written at the National University of Distance Education, in the Faculty of Law, recommends the enactment of a Law Against Medical Malpractice. In this regard, we mention some salient points derived from the analysis of this aspect.

The formulation of a draft Law Against Medical Malpractice took place in Venezuela during 2015, drafted by Representative Juan Bautista Pérez, mentioning some already known generic concepts such as expert, expert, negligence, among others. However, most of the

Authors consulted in our research warn that the creation of coercive laws against medical malpractice crimes would only result in higher costs for medicine, since doctors would look for ways to protect themselves against potential suing clients, opening the field for insurance companies to offer medical malpractice insurance policies in addition to defensive medicine, that is, all those actions conducive to the protection of the doctor from a possible lawsuit, requesting unnecessary tests and using evidence-based medicine, and - most likely - all this would further result in the divorce of an already deteriorated doctor-patient relationship. Dr. Acciarri (2013,293) has suggested that the problem with the transposition of laws could be exemplified by a doctor who had the same medication for all his patients, and when he gives it to a particular patient it has no effect and he says: ... - "well, it's the patient's fault, because this medication was excellent"... Evidently the situations of each country are particular and the relevant details for a norm to have adequate or inadequate results are much more than the mere copy of norms that were good (in the opinion of whoever in their countries).

On the other hand, let us remember that there is the so-called responsibility of legislators - and something here is interesting - legislators are people and they are not one, but many; the fact is that in our traditional legal education, we are accustomed to hearing about "the legislator," and that "the legislator does not make mistakes," and that "the legislator must be interpreted because he always has a good solution behind him." It seems that the economic analysis of law demystifies this perspective, the so-called hypothesis of the rational legislator or the infallible legislator, and makes us think that norms are nothing more than contingent elements, which are born at one time and end at another, and have better effects in one scenario and worse in others. And undoubtedly, the idea that legislators understand that with each norm

They are projecting consequences, that the relationship between norms and their effects is not the same as the relationship between norms and the purposes that legislators have in mind. (Acciarri, 2015, 320) The effects of norms go beyond what is desired, and that is precisely why the economic analysis of law instrumentally studies what happens between norms and the desired or undesired consequences. It can be studied whether the norms are technically suitable to achieve those desired consequences and it can be studied what the consequences of undesired norms are, or even those not foreseen by legislators, because the real world is usually very refractory to our mere intentions; my intentions about the world normally do not materialize if I do not follow a technically adequate path. The economic analysis of law attempts to study what that technically adequate path is, for example, a norm that seeks to favor tenants or lessees in a contract, in the end what it does is harm them, reducing supply and raising costs. This is, without a doubt, one of the most classic examples, and we have multiple experiences of this in Latin America, where norms that are intended to benefit a certain class of people or a certain group of people end up harming them. So, we tend to move between two ideological extremes: "it's all or nothing"; the economic analysis of law says: - "this is a much more complex problem, and many more things must be studied to achieve certain effects." It is not always, and almost never, a matter of continuing to create norms; it is often thought that a legislator is more productive according to how many norms they produce and therefore, a parliament is more productive if it continues producing norms. And the problem of productivity - understood in terms of social improvement - is not usually correlated with quantity but with much deeper things, such as the quality of the norms. And the quality of the norms depends on their instrumental value, their possibility of achieving - instrumentally - correct ends.

studies the economic analysis of law. The usual philosophical approaches normally include the technical value of norms as a component of legitimacy. In this sense, if law were a mere game, an intellectual game between two or three people, between two parties and a judge, we could forget about what happens in the world with these norms. If, on the other hand, we understand that law is a social science and a social practice; that is, if law, on the one hand, is a discipline that studies a social practice, and living law is a social practice, it seems a little strange to be able to ignore what these norms produce, what they favor, or what they restrict in the world. Thinking that the legitimacy of a norm is merely the acceptance of a set of words, or the acceptance of the deontic status (prohibited or permitted) of a certain behavior seems to fall far short of what we would understand if we were correctly and comprehensively explained what norms are, what we would understand as right and wrong in a norm. Therefore, one of the virtues of economic analysis of law is that it reveals certain issues that concern us but that we do not systematically study. (Acciarri, 2015, 345)

CHAPTER VII

LAW, MEDICINE AND SOCIETY

Defensive medicine is one of the most worrying realities in the healthcare world. This attitude is practiced by many doctors to protect themselves from potential lawsuits, leading to an increase in the prescription of unnecessary diagnostic tests and treatments that have no scientific basis. These excessive measures not only increase the cost of medical care but can also cause real harm to patients. As an essential part of our research, we address this and other aspects in this section of our thesis.

In addition to defensive medicine, we also encounter medical defamation, a phenomenon that occurs more frequently than it should and is spread through various media, such as sensationalist journalism. This practice consists of discrediting the work of a doctor, suggesting that they have made mistakes or performed certain actions negligently, without necessarily providing sufficient evidence. This situation can lead to a public lynching of health professionals, with disastrous consequences for their reputation.

In today's world, medicine is facing a profound crisis, both scientific and social. Scientificity is fundamental in medical practice, but the effectiveness of the measures implemented must also be taken into account. In many cases, medical practice has become an exercise in excessive interventionism, which neglects the individual needs of the patient and focuses on treating the disease rather than the sick person.

In this sense, we must emphasize the right to health as a fundamental human right. It is crucial to have a society that cares about the health of its citizens and is capable of guaranteeing universal access to quality medical care. We must work to eradicate defensive medicine and medical defamation, as well as to improve medical practice and further humanize medicine. All of this is

necessary to ensure that society has quality medical care that adapts to the needs of patients and respects their rights.

7.1.-Defensive medicine.

Errors in the medical field are often unpredictable and inevitable, and the working conditions under which the healthcare team operates are a major factor in creating unsafe or risky practices in medical practice. In modern society, the idea lies beneath the collective unconscious that every health problem, whatever it may be, must be resolved and always have a happy ending. Otherwise, it is unacceptable, and when this happens, the culprit must be found: the doctor.

In 1978, Tancredi defined the concept of defensive medicine as the application of treatments, tests, and procedures with the primary purpose of defending the physician from criticism, avoiding controversies or potential malpractice lawsuits, and potentially going beyond diagnostic and treatment considerations. (Ramirez, 2017, 62)

Normally, when a medical error occurs, it is treated punitiously; the doctor's guilt is immediately assumed, so there is a tendency to avoid reporting it because it is believed to benefit no one. The doctor, on the other hand, goes through a media-social lynching, which issues biased verdicts and a long judicial process, only to be acquitted later, in most cases, when the absence of negligence is truly proven. The doctor remains alone, generally without the support of his colleagues or the institution. In his personal sphere, he goes through a series of psychological disorders with repercussions on his private, professional, and economic life. (Sánchez, 2005, 201)

In Spain, around 1986, a boom in medical claims began, which increased defensive medicine. However, there are numerous factors that interact with each other and have increased litigation. The trend is that, in practice, defensive medicine will increase.

In the United States, in 2000, the cost of lawsuits ranged from $41 billion, to $200 billion annually in 2008, representing 10% of total health spending in that nation. Most medical lawsuits are related to the information provided to patients and their families, and very rarely to the effectiveness of medical practice. Hence the great importance of informed consent and the development of a good and effective doctor-patient relationship, including the family members responsible for the case.

In a schematic manner, we have distinguished several conditioning factors that promote defensive medicine:

Factors influencing the physician	**Patient conditioning factors**	**Factors conditions of thesocial environment**
Poor doctor-patient relationship	Better medical information	Stricter laws
Application superficial ofclinical procedures	Greater access to the media.	Immediate and massive dissemination of medical news (both positive and negative)
Knowledge, skills andpoor skills.	Elderly knowledge of your rights	Information bias
Invasion of fields of medicine that No domina (medical intrusion)	Prepaid medicine	
Overconfidence.		

Taken from (Ramirez, 2017) and modified by us.

The literature reviewed indicates that the most frequent causes of claims and lawsuits against physicians include delays in patient care, errors in diagnosis, fatal consequences resulting from performing both diagnostic and therapeutic procedures, the application of erroneous practices or incomplete treatments, such as incomplete tumor resection, or the death of a patient. We can mention, for example, that in the United States (US), it is customary to sue for medical malpractice for reasons such as professional fees earned by doctors, the loss or breakdown of the doctor-patient relationship, the existence of medical malpractice insurance, and the attitude of lawyers. (Hickson, 2002, 2951)

7.2.-Moral damage due to medical malpractice

In the criminal field, moral damage has been defined as that which consists of suffering and not only physical suffering, including anguish, affliction, bitterness, worry, anxiety and other similar psychological disturbances. Because all the above adjectives somehow encompass pain, this type of compensation is known as pecunia doloris. The concept has been expanded and currently includes emotional affectation. Therefore, it must be proven that the moral personality of the person who suffered this type of damage has been truly affected and that it is not a simple susceptibility. Likewise, the causal relationship of this suffering with the action or omission of the person accused of being responsible for it must be established.

In medical practice, all these aspects are particularly relevant. An inadequate explanation by healthcare personnel to a patient about the treatment regimens required to cure a condition would fall within the scope of moral damage.

Article 1.185 of the Civil Code (CCV) establishes the conditions for liability for damages, referring to the unlawful act, while Article 1.196 (ejusdem) specifies the scope of liability, what moral damages encompass, and how it should be determined by the judge. Art. 1196 CCV: "The obligation to provide reparation extends to all material or moral damage caused by the unlawful act. The judge may, in particular, award compensation to the victim in the event of bodily injury, an attack on his or her honor, reputation, or that of his or her family, or his or her personal freedom, as well as in the case of violation of his or her home or violation of a secret concerning the injured party. The judge may also award compensation to relatives, associates, or spouses as reparation for the pain suffered in the event of the death of the victim."

In general terms, an unlawful act can be described as a negligent act that causes damage, not tolerated or consented to by the legal system.

In positive law, this action can be positive or negative depending on whether the agent causing the damage carries out an action or omission. The nature of the wrongfulness is fundamental to its determination, and the judge may award compensation to the victim.

If a plaintiff alleges medical malpractice by a physician, it would be their burden to demonstrate how the physician's actions caused the harm or what act or omission by the physician triggered the complication that gave rise to the harm. As has been ratified by legal doctrine, wrongful acts require proof of all three elements: harm, fault, and causality. The plaintiff must prove the latter. Although there is freedom of proof in this regard, the Court believes that expert evidence is the best and most essential evidence for proving it.

In those cases where moral damage is claimed due to medical malpractice, the existing jurisprudence in the place where the involved parties are located must always be taken into account, always remembering that beyond criminal, civil or moral reparation, all these situations in general lead to the deterioration of the image of the personnel and health care institutions, fostering a feeling of distrust in the population when it comes to needing attention from them. (Pietri, 1988, 107)

Society must be aware of the requirements of the criminal law system regarding medical liability, which will allow for a healthy and appropriate oversight function. The combination of a defensive attitude on the part of a doctor who practices his profession with fear and a distrustful community generates an unsatisfactory, unsafe, and expensive medical service. In this sense, a physician's professional activity is essentially evaluated in terms of what should be done in each situation. The doctor has the right to be judged according to the criteria of the school he claims to follow; a newly graduated general practitioner is not required to apply the level of competence of a specialist. However, in certain

circumstances, if you have an obligation to refer a patient and fail to do so, you could be considered negligent. Therefore, you must possess an average skill level necessary for the location in which you practice.

Certainly, there are aspects such as failure to follow orders or instructions that can also lead to culpable behavior. In this sense, foreseeability can be considered the best guide and orientation for proving generic recklessness or negligence. The conduct cannot be blamed if there is no possibility of knowing it in advance. The inevitability of the event must be added. However, even if foreseeable, if it is an exceptional outcome with minimal probability of occurring, we could end up excluding culpability. This is why medical guilt finds its limit in situations that are insurmountable for the doctor. No reproach can be directed at him in the face of the impossible, which should calm the conscience of the physician when he works in deficient conditions lacking the most essential, in the face of which nothing can be done, with all the blame falling, as Mantovani points out, on the healthcare structure, unless culpable omissions by this professional can be identified in order to request the intervention of the competent public bodies. (Mantovani, 1980)

Given that medical work is almost always performed by a team, the liability of the professional who notices the error of another colleague in the treatment of a common patient and does nothing to prevent it is not excluded, as is the liability of the person who is responsible for leading the group by exercising oversight and control in medical decisions. Therefore, in order to determine the degree of guilt, the judge must take into account the specific situation of the individual to whom the culpable behavior is attributed, being obliged to assess the specific conditions, characteristics, peculiarities, and normal knowledge.

presumably, with these data and criteria, always relative and not absolute, one can reasonably reach sound conclusions.

The LEM outlines the ideal institutional conditions for providing adequate medical care. In this sense, a line exists between the personal liability of the physician or any member of the healthcare team and that of the institution itself, which must comply with all legal requirements for providing services to individuals. It follows that, in the event of a failure in healthcare services, the clinic, as a legal entity, would assume a type of indirect liability to the victim. This does not appear to be considered a purely objective liability, unlike the liability established for physicians, which is civil, criminal, administrative, and ethical. The role and responsibility of healthcare institutions is considered equally important, as they are obligated to provide high-quality care.

7.3.-Medical defamation. Yellow journalism

Generally, defamation of a physician constitutes an intrusion into the physician's right to honor, influencing his or her professional discredit and attacking his or her dignity. When news reports do not focus on the objective truth of the facts, but rather, through sensationalist press, present eye-catching, scandalous, or exaggerated headlines in an attempt to increase sales and impact the physician's professional activity, this constitutes moral damage, an abuse of rights, and, worse still, generally sows distrust, hopelessness, insecurity, and social hatred in the collective unconscious of society, which hinders the process of healing and improvement, as well as hinders the doctor-patient relationship, thus requiring greater efforts by the physician to gain the patient's trust.

One of the best-known rulings is the case of the El Nacional Publishing House. CA, as well as several of its journalists, including Hercilia Garnica and Ibeyise Pacheco, against Adolfredo Pulido Mora. In addition to the monetary compensation imposed on the publisher El Nacional, CA also granted Dr. Adolfredo Pulido Mora the right to reply on a full-page copy. In Venezuela, there is no preventive recourse for these situations. However, since 2015 in Mexico, the Jalisco Medical Association and the Mexican Medical Association (AC) have been studying the possibility of presenting a draft platform to the media that would allow them to verify cases of medical malpractice.

Nowadays, it is common for patients or their families to make value judgments about the performance of the physician, health care personnel, and the institutions where they receive care. This has made a profound difference in relation to their attitude throughout history, since in the past, there was complete trust in the diagnostic and therapeutic decisions of the physician, based on the fact that he always acted with a great sense of responsibility, honesty, ethics, and knowledge to maintain or restore health in the most complete and satisfactory way.

It is assumed that the change that has occurred over time has modified the doctor-patient relationship, the causes of which range from society and its values, the expectations of healing of the patient, based on technological advances in medicine, the commercialization of health services, bureaucratization, the lack of commitment often shown by both the doctors themselves and the entire health team, added to this, the risks inherent in each procedure, both diagnostic and therapeutic, not exempt from failures or adverse results, and the often sensationalist information in the media about medical malpractice, all of which has contributed to changing the way society thinks about doctors, institutions and the health team in general. As if that were not enough, the

access that exists today to information available on the Internet, which can sometimes be wrong or misinterpreted by the patient, generating anguish, doubt or distrust in the patient and their family, being misunderstood by those who do not have the necessary training and leading them to demand treatments that seem successful and to criticize doctors who do not accept to apply them, without considering that generally they are the only ones qualified to make individualized and appropriate decisions in the specific case.

7.4.-Medical crisis and malpractice

When studying the medical crisis that humanity is currently suffering from, the problem of the functioning of the institutions of knowledge and medical power stands out between the years 1940-1945 when the famous "Beveridge Plan" was developed, where England and other countries served as a model for the organization of a health system after the Second World War, consolidating the right to life and health. The "Beveridge Plan" or the creation of the health system, meant that the State began to take charge of the health of its citizens, and although since the 18th century one of its functions was to guarantee physical health, it was not until the mid-20th century when it included the improvement of the individual's work capacity and their training for defense against possible military attacks on a nation. (Illich, 1995, 67)

In such a way, that the decade 1940-1950 contributed to the construction of a new law, moral, economic and political body, from there, the latter became one of the main objectives of the intervention of the State, however, its participation in health dates back to ancient times, although health is understood as the bio-psycho-social well-being of the individual, we could point out that in the time of Constantine, the State took on the task of caring for the souls of all its citizens, not only should it fulfill the traditional functions of the Empire, but also allow the

souls could achieve their salvation and even force them to do so, this being a historical fact of the State's intervention in health matters.

The current world conceives that in most countries, one of the purposes of state intervention is health care. Medicine is modernized and nationalized. Antibiotics are discovered, signifying vertiginous technological progress, simultaneously with a political, economic, social, and legal mutation of medicine. From that moment on, the crisis of medicine was established, with the manifestation of two phenomena: technological advancement, which represented progress in the fight against disease, and the new economic and political functioning of medicine. This did not produce the improved health welfare that could have been expected, but rather a curious stagnation of public health. (Foucault, 1976, 66)

In reality, it would not be entirely correct to think that medicine has remained an individual activity, between the patient and their doctor, and that it has only recently undergone socialization. It has always involved, to a greater or lesser extent, healthcare institutions, nurses, paramedics, consultants, family members, and physicians.

Perhaps the problem lies not in whether we require individual or social medicine, but in the model that has developed since the 18th century, when medicine took off, accompanied by a technical and epistemological breakthrough of considerable importance and a whole series of social practices, these possibly being the causes that led to its crisis.

7.5.-Scientificity versus effectiveness in medical practice.

There are those who believe there is a gap between the scientific nature of medicine and its efficacy, based on the fact that its misuse can lead to death. Until recently, the negative effects of medicine were recorded as the physician's own ignorance, but what emerged since the beginning of the 20th century was the fact that medicine could be

dangerous in itself, not because of its ignorance or falsehood, but because of the extent of its knowledge as a science.

There is data on this, one of which points to the considerable decrease in mortality among hospitalized patients related to the doctors' strike during that same period in Israel, as well as the famous research by Robert Talley, who showed that in 1967, 30,000 Americans died in hospitals due to drug poisoning.

Regarding statistics on surgical procedures, particularly studies on hysterectomies in California (USA), they reported that of 5,500 operations performed, 14% were unsuccessful. A quarter of the patients were young women, and only 40% of cases were able to determine the real need for the procedure. All these facts did not call into question the scientific rigor inherent to medicine, but rather the problem of positive iatrogenesis.

Currently, the instruments available to doctors and medicine in general, precisely because of their effectiveness, produce results, some purely harmful and others beyond control, forcing the human species to enter a dangerous history, a field of probabilities and risks whose magnitude cannot be precisely measured.

It is well known that treatment with antibiotics has led to a general decrease in the body's sensitivity threshold to the attacking agents, and in certain cases, the abuse of these has promoted the production of resistant bacteria for which there is no treatment, which leads to a complication of the infection, generally with a fatal outcome, meaning that to the extent that an antibiotic is not used rationally and the body is prevented from defending itself naturally, it will be limited from contact with the immunological stimuli essential to develop the necessary immunological defenses of the patient.

In general terms, it can be stated that the very effect of medications, positive and therapeutic effects, has produced a disturbance, not to say destruction or depression of the individual's immune system, because viruses and bacteria, which may well constitute a potential risk, can in certain cases serve as protection for the organism that suffers an alteration due to the therapeutic intervention, leaving it unprotected against infections from which the body itself could have defended itself naturally.

Ultimately, it is unknown what the genetic manipulations carried out on living cells, bacteria, bacilli, fungi or viruses by means of science will lead to. Technically, it is possible to develop aggressive agents for which there are no means of defense, potentially creating an absolute biological weapon against the entire human species. This prompted US laboratories to request a ban on the genetic manipulations currently allowed, due to fear of biological warfare. Thus, the doors are opened to a quite new dimension of what could be called medical risk, understood as the difficult-to-break link between the positive and negative effects of medicine. (Foucault, 1976, 66)

Illustrating the above, the surgical technique used in the 18th century did not always allow the hospitalized individual to leave the institution alive, the discovery of general anesthetic drugs occurred during the years 1844-1847, considering that when a person was put to sleep a surgical operation could be performed, the surgeons of the time devoted themselves to this work with great enthusiasm, however, at that time aseptic instruments were not available since asepsis was introduced into medical practice in 1870. Now, there is no doubt that any surgical operation in the absence of asepsis, will not only constitute a risk but, almost certainly, will be accompanied by death, hence almost

Medical progress has always been linked to a certain degree of morbidity and mortality.

Paradoxically, in medicine, both ignorance and knowledge are dangerous. Therefore, to study and understand medical malpractice, the environment, institutional health factors, the availability or lack thereof of resources, the lex artis, ethics, and political factors—that is, all the determining factors—must always be evaluated, not as an abstract entity, removed from these circumstances.

It could be said that knowledge can represent a threat in inexperienced hands, that is, many advances in science such as novel techniques and procedures involve great risks and harmful side effects, not only because of their immediate consequences at an individual level, but on a large scale in human groups, it would be enough to illustrate the above by pointing out the side effects of the so-called dobutamine stress test, which can cause death from cardiac rupture, myocardial infarction, stroke, asystole, ventricular fibrillation, sustained ventricular tachycardia, supraventricular arrhythmias, hypertension, allergy and hypersensitivity, among other effects, it is for all the above reasons that these advances are considered to constitute one of the fundamental characteristics of the current crisis in medical science that require great professionalism, experience and ethics from those who practice them.

It is necessary to remember that the practice of medicine involves a series of risks to the health and lives of people, but despite this risk, in compliance with their professional duty, and even the Hippocratic oath, they are obliged to intervene to save the life of the person, because that is their fundamental mission. One of the most important aspects that arise in medicine, when professional work is carried out as a team by virtue of scientific progress in the various specialties, is the determination of the

field of action inside of the which each professional is responsible. (Chiossone, 1971)

7.6.-Health, malpractice and medical interventionism

In the 20th century, medicine began to take an interest beyond its traditional field, responding to a reason other than the patient's request. Thus, many companies, before hiring a worker, subject him to an evaluation of his health status, performing tests, hematological analysis to rule out diabetes or hyperlipidemia, pregnancy tests, HIV-AIDS, cardiovascular evaluation, and may not hire a candidate without an optimal opinion from the insurance doctor who evaluates him. That is, the individual is exposed to the expertise of the doctor who examines him and his opinion will have repercussions in his work sphere. There are many occasions in which laboratory errors have been found, such as false positive HIV results, unfairly exposing the worker to public contempt, to his honor and even inducing him to suicide.

The above could demonstrate that malpractice can also occur in the systematic and mandatory screening policy for the detection of diseases in the population requiring entry into the labor market, which does not respond to any request or demand from the citizen. Similarly, in some countries, a person accused of committing homicide must undergo examination by a psychiatric expert. These are all examples of medical interventions not requested by the patient.

On the other hand, since the beginning of the 20th century, sexuality, its behavior, deviations or anomalies, were linked to systematic medical intervention, a therapeutic, for homosexuals in Eastern European countries, such as the use of electric shocks, forced medication and involuntary confinement, which illustrate the pathologization since modernly the fact of being homosexual is accepted that it does not constitute an illness. The medicalization of life is one of the

Problems that currently contribute to the overcrowding of family doctor consultations and emergency services, simultaneously causing difficulties in providing high-quality care and frustration for a large proportion of professionals. Medicalization is understood as the process of converting situations that have always been normal into pathological conditions and attempting to resolve, through medicine, situations that are not medical, but rather social, professional, or interpersonal relationships. Medicalization is a continuous, self-sustaining and constantly growing process, facilitated by a situation in which society is losing all capacity for resolution and its level of tolerance. Its origin is multifactorial, with various causes and actors involved (society, the media, the pharmaceutical industry, politicians, managers, and healthcare professionals), with the healthcare sector playing a fundamental role in this process. Healthcare professionals are both actors and victims of this process. (Orueta, 2011, 33)

Health has become an object of medical intervention, ranging from water sanitation to housing conditions and urban planning. Consequently, it is no longer linked exclusively to disease. In fact, authoritarian intervention medicine is a growing field, both individually and collectively.

7.7.-Right to health as a human right

The Universal Declaration of Human Rights, which in article 25, paragraph 1, states: "...everyone has the right to a standard of living adequate for the health of himself and of his family, including clothing, housing, medical care and necessary social services." The International Convention on the Elimination of All Forms of Discrimination against Women, in article 11, paragraph "f", states: "The

right to health protection and safety in working conditions, including the safeguarding of the reproductive function." The International Convention on the Rights of the Child, in Article 24, states: "...the enjoyment by every child of the highest attainable standard of health...". It is important to remember that the right to health is strictly linked to the exercise of other human rights, such as: life, human dignity, housing, food, non-discrimination, equality, access to information, privacy, among others. Furthermore, the definition of health contemplated in the WHO preamble, which conceives of health as "a complete state of physical, mental and social well-being and not merely the absence or suffering from disease"; the reference in paragraph 1 of the aforementioned Article 12 of the Covenant is: "...the highest attainable standard of physical and mental health." It should be noted that the right is not limited to health care, but covers a wide range of socioeconomic factors that promote the conditions for people to lead a healthy life, extending the right to basic determining factors in health, such as food, nutrition, housing, clean and potable water, adequate sanitary conditions, and safe working conditions.

In the quest to improve the living and health conditions of human beings, and in preventive medicine, there is the need to provide them with environmental and socioeconomic factors or conditions, ignoring that another risk factor for people's life and health is undergoing medical and surgical treatments without the proper legal provision, which would allow a claim to be filed in the event of any eventuality, before, during, or after the medical procedure.

American Convention.

"Article 1. Obligation to respect rights.

1. The States Parties to this Convention undertake to respect the rights and freedoms recognized herein and to ensure to all persons subject to their jurisdiction the free and full exercise of those rights, without discrimination of any kind for reasons of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other social status.

“Article 4. Right to life.

1. Every person has the right to have their life respected. This right shall be protected by law and, in general, from the moment of conception. No one may be arbitrarily deprived of their life.

“Article 5. Right to personal integrity.

1. Every person has the right to have their physical, mental and moral integrity respected.

2. No one shall be subjected to torture or to cruel, inhuman, or degrading treatment or punishment. All persons deprived of their liberty shall be treated with respect for the inherent dignity of the human person.

From the general obligation to guarantee the rights to life and physical integrity, special duties of protection and prevention arise, which translate into duties of care and regulation. States must adopt the necessary legislative, social, educational, labor, or other measures to eliminate all discrimination associated with mental disabilities and to promote the full integration of these persons into society. These measures include measures to prevent all preventable forms of disability and to provide persons with mental disabilities with preferential treatment appropriate to their condition.

The relatives of victims of human rights violations may, in turn, be victims, since the right to psychological and moral integrity of some relatives of victims is considered to have been violated due to the additional suffering they have endured as a result of the particular circumstances of the violations perpetrated against their loved ones and due to the subsequent actions or omissions of state authorities in response to the events.

CHAPTER VIII

MEDICAL ERROR AND LAW

This chapter aims to analyze the problems related to medical errors and medical malpractice. This issue is of great importance in today's society, as a medical error or medical malpractice can have serious consequences for the health and well-being of patients.

First, it is important to distinguish between medical error and medical malpractice. Medical error refers to an improper action or omission by a healthcare professional that may lead to an adverse outcome for the patient, but does not necessarily entail a violation of medical care standards. Medical malpractice, on the other hand, involves negligent or reckless conduct that violates medical care standards and may lead to an adverse outcome for the patient.

Medical errors can be classified into different categories, for example: diagnostic errors, therapeutic errors, errors in medication administration, among others. It is important to note that there are medical areas that are more susceptible to medical errors, such as intensive care units, where patients are critically ill and where rapid and accurate decisions must be made in highly complex situations; also the anesthesia area, where constant patient monitoring is essential to avoid complications; and also plastic surgery and so-called aesthetic tourism, where the demand for low-cost aesthetic treatments can lead to procedures being performed without proper precautions and without the supervision of a qualified professional.

The commission of medical errors entails a series of ethical responsibilities on the part of healthcare professionals. In this regard, it is essential to emphasize the importance of transparency and honesty with patients and their families, as well as the need to carry out

Forward clear and effective communication to address the consequences of the error and provide the patient with the necessary means for recovery.

Compensation for medical errors is also a relevant issue in this context. It is necessary to address the potential liability that may arise from committing medical malpractice and analyze the various forms of compensation available for affected patients.

Ultimately, medical errors and medical malpractice are highly relevant issues in the healthcare field, as they can put patients' lives and health at risk. The task of healthcare professionals is to work together to minimize the occurrence of these errors and provide quality and safe medical care for all patients.

8.1.-Differences between medical error and medical malpractice

Medical malpractice	Medical error
Medical performance that is not in accordance with knowledgecurrent medical practices due to ignorance, laziness, imprudence or poor organization, which causes injury to the patient, temporary, permanent and even death.	Medical errors occur due to unknown effects of the interaction between the subject receiving the intervention (the patient) and the actions of healthcare personnel. Most of these errors are due to human error. that are potentially avoidable.
It occurs when there is: • Negligence • Inexperience • Failure to comply with rules and regulations • Dolo	It occurs when there is inaccuracy in: • Diagnostics • Therapy • Failure of preventive measures • Others
It usually involves a legal sanction	It usually carries a moral sanction.
It is related to a bad practice or care quality of medical practice	It is related to opinions contrary to the truth and the medical knowledge.

Source: Prepared by the authors.

8.1.1.-Medical errors. Classification.

Cases where the constituent elements of medical malpractice are missing give rise to the term medical errors, among which the following stand out:

1.- General errors: They can be triggered by poor communication between treating physicians, inadequate organization of shifts or guard teams, carelessness in the review of elements necessary to perform the medical act, such as forgetting to check if the oxygen cylinders, equipment batteries, gas, operation of electric light or substitute power plant, laboratory and radiodiagnostic service are stocked,

forgetting to check the status and expiration date of products such as blood products, antibiotics, prostheses, or the light of a laryngoscope, among others.

2. Diagnostic errors: These are generally due to errors in interpreting the patient's signs and symptoms, delays or inaccuracies in the presumed diagnosis, choice of tests, or incorrect interpretation of results. (Alvarado, 2009, 16)

3.- Treatment errors: Incorrect medical treatment, defective pre- or postoperative techniques or treatments, delay in making therapeutic decisions, inadequate surgical indication.

4.- Prevention errors: These are caused by poor therapeutic choices, generally in chronic diseases, or by failing to warn of drug interactions, failing to inform the patient about dos and don'ts during the course of therapy, illness or rehabilitation. This category includes inadequate antibiotic prophylaxis, for example before a colonoscopy or prostate biopsy, as well as poorly planned postoperative surveillance. (Rosner, 2000, 2089)

8.1.2.-Ethical conduct when making a mistake

Medical errors can have varying consequences, sometimes without repercussions on the body's physiology, but in other cases they directly impact the patient's health or quality of life. Some put the patient's life at risk, while others can result in death. Much of the ethical discussion focuses on whether or not to inform the patient of the error, and the barriers generally encountered include the physician's unwillingness to admit it, the implications this may have on colleagues, and the fear that doing so may lead to lawsuits or other legal action. (Leape, 2002, p. 1271)

In her book "Error in Medicine: Clinical Autopsy as a Tool for Quality Care," the author emphasized that avoiding reporting medical errors made their prevention difficult. In some countries, the healthcare system

It allows and conceives admitting reporting a medical error in the patient's medical history or other document, as this facilitates its correction, prevents its repetition, and may represent an extenuating circumstance in legal cases when the error is revealed by other sources. (Martín-Polo, 2011)

Generally, the laws recognize that doctors can make mistakes, as long as there is no negligence, but the interpretation of this is, nevertheless, very variable, therefore, it is always highly recommended that the same doctor inform the patient of the error and give an objective and narrative explanation, never in a defensive or evasive manner but acknowledging that he regrets what happened. Addressing this point, in countries such as the United States, Internet portals such as*www.sorryworks.net* where they surprisingly point out that both doctors and nurses have not historically been trained to apologize and health personnel have associated it with future lawsuits, since apologizing is admitting that a mistake was made, however, there is a big difference between showing empathy or empathizing and apologizing. (Mitka, 2005, 2294) In the US, all health personnel are advised to show empathy after an adverse event, even if it is thought that only an error has occurred and it is recommended to apologize if after an exhaustive review it has been determined and proven its commission. (Bernstein, 2007, 208)

Many lawyers point out that very different outcomes could have been seen if the doctor hadn't acted evasively but refused to report the matter, and they point out that demonstrating empathy is key to maintaining communication and a doctor-patient relationship after a mistake has been made.

Now, we must emphasize that there are acts such as amputating or removing the wrong organ, incorrectly administering nutrition intended for enteral use intravenously, which cease to constitute errors and become malpractice, because these errors would not occur under conditions of careful practice, if professionals acted with caution in the

In the exercise of their profession, unlike acts such as puncturing a lung and causing a pneumothorax when attempting to drain a pleural effusion, or puncturing a colon and causing peritonitis during a colonoscopy procedure, among other cases, these are situations that can occur even if all precautions have been taken and that remain categorized as medical errors. Occasionally, some cases in medical practice become more complicated, finding that the difference between malpractice and medical error may not be so explicit depending on some conditions. Therefore, it is considered that making mistakes is human, hiding them is unforgivable, and failing to learn from them is inexcusable.

In cases where medical malpractice is suspected, before filing a lawsuit, the different aspects that a litigation would involve should be considered, in order to predict its success or failure, factors such as the time it will take to bring a trial to a successful conclusion, the financial resources available, access to documentation, medical history, other studies, that is, everything that is useful to form the evidence that proves that medical negligence has indeed been committed, always being advisable the advice of a lawyer specialized in this area, and in turn the collaboration of a doctor or expert expert in the damage caused, to confirm that the patient was the victim of a crime of a negligent nature. The lawyer will be in charge of guiding the compensation and will put in place procedures to make the claim effective, being able to demand liability for the damages produced both criminally, civilly and administratively. (Carrillo, 2011, 1216)

Medical malpractice lawsuits can be considered a wake-up call or warning, revealing many dark facts or deficiencies in the functioning of both the physician's actions and the institutions' operations. They are important for identifying flaws and errors so they can be corrected.

8.1.3.-Susceptibility to medical errors in Care UnitsIntensive Care (ICU)

The dividing line between medical errors and malpractice may often not be so obvious. In order to demonstrate this, it has been decided to explore some medical disciplines and their vulnerability to error. It is worth highlighting that the United States Institute of Medicine (IOM) published an article entitled "To Err is Human" in 1999, estimating that medical errors caused between 98,000 and 440,000 deaths per year in that country and determined that ICUs represented a substantial part of the challenges facing patient safety. It is important to highlight that work within ICUs is characterized by its high complexity and generally requires making urgent, high-risk decisions in a short period of time. Individuals whose identification and medical history may be unknown or poorly provided by others or family members must be treated by physicians with various levels of critical care training or by interconsulting specialists. Errors made in medical indications are related to a high proportion of incidents and adverse events. The drugs most frequently associated with errors in the (ICU) are cardiovascular drugs (24%), followed by anticoagulants (20%) and antibiotics (13%), generally occurring during procedures or administration of treatment (74.8%), especially due to the medical order or its interpretation.

The staff working in the (ICU) must recognize their limitations in the care of certain diseases or complications in which they are not adequately prepared, and the attending physician must warn the patient, their family members or representatives of this in order to be able to propose options, such as consultation with other specialists in order to strengthen the diagnoses and conduct. (Donchin, 1995, 294) It is important to recognize that in the face of

In the event of specific complications, it may be appropriate to transfer the patient to a more specialized or better-resourced center. The principles of ethics, autonomy, beneficence, and justice must be key elements that physicians use to base much of their decision-making in the ICU. (Rothschild, 2005, 1694)

8.1.4.-Mistakes in critically ill adults

In industrialized countries, with the aim of optimizing the quality of health care delivery and minimizing the possibility of errors, especially in the treatment of critically ill adult patients, a review of scientific publications was conducted between 1985 and 2008. The errors committed by ICU nurses reported in patient records were examined. It was evident that they were forced to follow medical indications with a wide variety of drugs at different doses in the same patient, which would be an added risk factor for unsuccessful treatments. Furthermore, work in ICUs is unique in that it requires great clinical skill and meticulousness due to the high complexity of operating within these health structures, since they work with patients with a reserved prognosis and highly susceptible to serious consequences when errors are made. In the opinion of Yepes (2003,45) in the resuscitation phase, jurisprudence has indicated that the work of monitoring and preventing events that lead to cardiorespiratory arrest is very important due to the complications that may arise and that require attention by qualified personnel, pointing out in a judged case that "...immediate intervention, from the first signs of respiratory problems, would have ensured the survival of the patient..."

In Fahimi's opinion (2008,110), errors in medical indications, especially in treatment, have been defined as preventable in the prescription or in the inappropriate use of a medication that has caused

Damage. ICU nurses can often make errors when calculating and administering drugs, but also when preparing doses. The antibiotics most frequently involved are amikacin, vancomycin, metronidazole, and ciprofloxacin.

Regarding cardiovascular drugs associated with errors, the following are mentioned: epinephrine and digoxin, as well as electrolytes such as potassium and magnesium. Among the factors commonly associated are distractions by nursing staff and poor communication between doctors and nurses. It is worth noting that similar errors include a lack of understanding of the stability and bioavailability of various drugs, which can often lead to drug overdoses. This is the case with opioids, which can cause severe respiratory depression in patients who are breathing spontaneously and not significantly affect a patient on mechanical ventilation. (Valentin, 2009, 814)

8.1.5.-Neurological emergencies and error vulnerability

A considerable proportion of patients presenting to the emergency department present neurological symptoms, the most common of which are headache, backache, drowsiness, and seizures. We will highlight below that headaches account for approximately 2% of emergency room visits. Diagnostic errors in subarachnoid hemorrhages have been reported in 12% to 25% of cases, likely related to the wide variety of clinical presentations, failure to follow a workup algorithm, failure to understand the limitations of neurological diagnostic scales and tests, and the fact that not all patients with subarachnoid hemorrhage have an abrupt onset of headache, and some patients' headaches improve with analgesics. (Kim, 2011, 34)

Along these same lines, some time ago, the American press reported on the case of a patient who went to a health service

urgently due to a severe headache, at that time, the doctors did not find any abnormal data in the clinical examination and considered that she did not present any urgent problem and after the improvement of the symptoms they sent her home with the instruction that she go to a check-up with her usual doctor, later the patient died as a result of what appeared to be a subarachnoid hemorrhage. (Vermeulen, 2007, 1110)

Although this problem may have been diagnosed during admission to the Emergency Department, through a lumbar puncture or a cranial computed tomography (CAT), the indication for these tests depends both on the information the patient provides to the physician and on the physician's experience in suspecting it. (Edlow, 2008, 237)

In the case in question, if the patient had told the doctor that this was the most important headache of her life, or that she had never had headaches in the past, these tests should have been performed and not doing so would be classified as negligence, but if, on the contrary, the person recounted a history of repeated headaches for years and did not express that the current headache had special characteristics, these tests should not have been performed, because doing them indiscriminately to everyone with a headache would have more harm than good, in this case it would be an error of judgment, since a severe headache was confused with a mild one and the family could demand compensation for the damage caused and the doctors would be free of blame without professional disqualification or criminal action. (Bø, 2008, 1293)

Among the reasons for neurological consultation that can lead to errors are described:

1. Back pain: The most common causes include cauda equina compression, herniated disc, tumors, abscesses, and hematomas. For a proper diagnosis, in addition to a thorough history and physical examination, a magnetic resonance imaging scan is necessary.

(MRI), cauda equina syndrome may be misdiagnosed when there is an incomplete medical history, errors in the physical examination, in communication between physicians, or between physicians and nursing staff members.

2.- Drowsiness: This is another reason for consultation to the neurological emergency room, when an individual comes presenting generalized drowsiness, they may have some toxic-metabolic problem that includes electrolyte abnormalities, dehydration, side effects of medications or systemic infections. Less frequent causes of generalized drowsiness include Guillain Barré syndrome, an immune disorder of unknown etiology that generally occurs in adults aged 30 to 50 years, transverse myelitis, a neurological condition due to an inflammatory process of the white matter of the spinal cord, which can cause axonal demyelination, myasthenia gravis is also mentioned, a disease characterized by pathological muscle weakness or fatigue caused by an autoimmune disorder; Periodic paralysis, a rare hereditary condition that causes episodes of progressive muscle weakness, the two most common types of which are hypocalcemic and hypercalcemic, and botulism or botulinum toxin poisoning, a bacterial neurotoxin produced by the bacterium Clostridium botulinum, the most common route of poisoning of which is foodborne illness.

3.- Dizziness: Like headaches, dizziness is another condition that can range in meaning from benign to very serious, and this can make it difficult to distinguish them. One of the elements that contributes to misinterpretation is the use of inappropriate words by patients to describe their own symptoms. In the case of dizziness, the patient often uses the words "vertigo" or "spinning sensation," which are not useful for identifying the condition. There is a very narrow line between confusing, for example, vestibular neuritis and labyrinthitis with a cerebellar apoplexy or a stroke.

brainstem. Similarly, a poor or inadequate physical examination and an inaccurate medical history lead to an inaccurate diagnosis. The following table exemplifies diagnostic errors in some common neurological emergencies, summarizing important data that should be collected from the medical history, physical examination findings, thorough neurological examination, and differential diagnosis with similar pathologies that can cause confusion:

Atypical presentations of cerebrovascular syndromes:

	Pain of head	**Dizziness**	**Pain low in back**	**Sleepiness**	**Seizures**
History	The sick used th e word “migraine” eit her“sinusitis” that can be confusing to thephysician when there is a previous history of these diagnoses.	The use of the word vertigo or spinning sensation N o It helps a lot to clarify a diagnosis.	The sick usethe word “sciatica” that can be confusing to thedoctor and put “sciatica” in the diagnosis.	Patients may report “clumsiness” or “heaviness in the upper or lower limbs” instead of using a more appropriate word to describe their discomfort.	The Patients often say: "convulsion"after presenting a fainting.S ome patients may present with altered mental status or post-ictal Todd's paralysis.
Physica l examin ation	The patient with subarachnoid hemorrhage may to look good and Neurol ogical examination may be normal	Sick wh smalsuggestlesions ofst roke in the posterior cerebral circulation may mimic a presentation peripheral vestibular .	Patients with serious etiologies of low back pain may N opresent neurological deficits.	Patients with stroke may present with a deficit, depending on the occluded vessel. Myasthenia gravis has intermittent symptoms. that They wax and wane, and Guillain Barré may present with only sensory symptoms.	The Patients may feel lethargic, butwith an apparently normal neurological examination.
Diagnostic test	For subarachnoid hemorrhage the CT isgood, but not like this for the diagnosis of dissection cavernous sinuses cerebral.	Tomography (CT) may eventually N o detect a brain stem infarction.	It is not evaluable by magnetic resonance imaging (MRI). MRI should be performed on the affected spinal segment.	In the early stages of strokes, the (TAC) can deliver results falsely normal.	He electro- An encephalogram is not generally available in the emergency department. Lumbar puncture should not be performed in patients with neurocysticercosis .
Information *on purpose*which can lead to a misdiagnos is.	“A headache that is relieved with ergotamine or painkillers is not due to a serious cause.”	“The apoplexy of the posterior circulation has symptomsnotorio us or it is a devastating event”	"all the patients with spinal epidural abscesses haverisk factors, fever either neurological defici”	“Young people do not suffer strokes or cerebrovascular accidents frequently.”	“Seizures or similar movements are some sometime s interpreted as apoplexy. Convulsive movements arecomm on in the “syncopates.”

Taken from Edlow (2008,237) and modified by us.

8.1.6.-Errors in anesthesia, vulnerability and latent conditions.

Safety in the handling of anesthetic drugs has improved over time due to the advent of more reliable and safer drugs, as well as the existence of good quality equipment, but the use of polypharmacy, the complex working conditions involving physicians and paramedics with multiple levels of training, can expose this area to a medication error at some point in the anesthetic procedure, leading to high mortality and morbidity, prolonged hospital stays, costly treatments and legal disputes.

The Japanese Society of Anesthesiology (JSA) investigated 27,454 anesthetic procedures over an eight-year period (1999–2007) and found a total of 233 medical errors involving overdose, drug substitution, and omission of anesthetic medications. (Yamamoto, 2008, 248)

Errors in the administration of anesthetic medication: They are divided into two groups, according to the work system, active failure and latent conditions, the first of these, active failure is considered as the unsafe acts committed by anesthesiologists who are in direct contact with the patient due to errors in prescription, judgment, inference, and interpretation, while latent conditions mean that individuals within the health care system make decisions with poorly evaluated future consequences, that is, not foreseeing the side effects or sequelae that the patient will suffer. In the past, due to the limited availability of anesthesiologists, the risky practice of administering simultaneous anesthesia was common, in which the patient was abandoned not only between rooms of the same institution, but also between distant hospitals. Currently, this is considered illegal conduct within the specialty and, taking into account the helpless state of the patient when undergoing anesthesia, it becomes an attack on the trust placed in the

anesthesiologist, therefore, the blame also falls on the surgical team and the institution that condones these procedures. Simultaneous anesthesia is considered—unlike a medical error—malpractice, where errors are inexcusable. (Navarro, 2014, 265)

In England, the Royal College of Anaesthetists, the body responsible for ensuring the quality of care and safety of patients undergoing surgery, emphasizes that a properly trained and experienced anesthesiologist must be physically present for all anesthesias: general, regional, and procedures requiring sedation. Simultaneous anesthesia should not be permitted; it is unjustifiable and can cause adverse events and violate patient safety. This type of illegal act, regardless of the motivation (lack of anesthesiologists, profit), should be prohibited, as it assumes responsibility for all risks: administrative, criminal, civil, and ethical, as well as loss of reputation, credibility, and prestige. In the 2009 Manual for the Application of the Surgical Safety Checklist, the WHO requires the presence of an anesthesiologist at the beginning, during, and at the end of surgery. (Merry, 2001, 385)

In anesthesia, the majority of critical accidents occur during induction (42%) and the start of the procedure (17%). Errors also occur during drug administration (53%), followed by prescription (17%), preparation (14%), and transcription (11%). (Stouman, 2004, 493)

Human error is believed to be a factor responsible for 65 to 87% of deaths during anesthesia. In several studies, the drugs frequently linked to errors in the practice of anesthesia are induction agents such as sodium pentothal, ketamine, muscle relaxants, narcotics, sedatives in general, anticholinergics, and local anesthetics. The confusion arises due to their erroneous use.

Identification, mislabeling, wrong syringe, interchange with other drugs or medications. (Kothari, 2010, 187)

Anesthesiologists are one of the few groups of physicians personally responsible for the administration of a drug. During the anesthetic procedure, most errors are totally or partially attributed as an inherent part of human activity and psychology. Consequently, their occurrence can only be reduced, but not eliminated. The horizontal and vertical distribution of work has been proposed in doctrine to differentiate between cases of autonomy or subordination among team members. The surgeon-anesthesiologist relationship has been classified as a horizontal relationship, since both professionals have technical and scientific autonomy. (Yepes, 2003, 65)

8.1.7.-Medical errors in surgery. Aesthetic tourism. Liposculpture For decades, medical personnel have resorted to manually counting the sponges, needles, scissors, retractors, and other devices used during operations before completing the surgical procedure. Sometimes there are more than a hundred. Therefore, the University of Michigan has devised bar-coded sponges, which are scanned twice, once when they are used during the procedure and again when they are removed from the body. If there are discrepancies in the count, the surgeon knows to search the surgical area for the missing gauze or instrument. According to experts, gauze is the object most frequently left behind in the body after surgery. X-ray equipment is used to find lost objects while the patient is still in the operating room; X-rays can identify metallic objects as well as soft objects. In addition, these new bar-coded sponges contain a radiation-opaque label, which allows them to be detected during an X-ray. The wards of the University of Michigan Cardiovascular Center and CS Mott Children's Hospital,

They are part of an initiative to prevent the forgetting of surgical items retained inside the human body. There have been no such incidents in the past year, and researchers hope to extend this initiative to other hospitals. (Campaign, 2006, 390)

Cosmetic surgery, so in demand today, was not always well received. In Italy in 1956, it was difficult to perform because it was considered sinful and vanity. The nuns who ran the hospitals did not grant surgeons surgical appointments to perform it, always arguing that the operating room was busy. (Coiffman, 2015, 418)

However, the situation has changed radically over time, to the point that in recent years, so-called aesthetic tourism, which combines vacations with cosmetic surgery, has become fashionable. In this regard, the president and the representative of the Spanish Association of Plastic Surgery have mentioned that this is a high-risk combination for patient safety, since low-cost surgeries often have poorly trained personnel, reaching medical intrusion, for this reason the patient should investigate the doctor's credentials and have the surgery performed in accredited hospitals, never in offices, shopping centers, hotels or other environments that do not guarantee the safety of the patient in the event of emergencies, in order to avoid accidents due to imprudence and non-compliance with healing times, because these surgeries generally exceed seven days, a time that exceeds what is normally offered by aesthetic tourism packages and depending on the wounds, the stitches would have to be left in for up to ten or twelve days, carrying out follow-up and evaluations without forcing periods and in case of any late complications, you should return to the country where the surgery was performed, although this does not always happen, having to a new doctor face complicated cases that require a second intervention.

In South America, there are markets selling used breast implants at low prices: they are removed, washed, sterilized, and then sold, used and worn. However, it should be noted that this type of trade in medical and surgical supplies does not exist in other countries.

It is well known that every surgical procedure involves risks, and liposuction is no exception. Historically, it was a technique invented by Italian gynecologist Giorgio Fischer, who, while on vacation in Los Angeles (USA), observed the effect of a machine extracting oil from the ground and wondered if he could create something similar to eliminate fat from the human body. The technique uses cannulas that extract 60cc of fat in 10 seconds, meaning the patient needs to be under anesthesia for less time, therefore, the surgery and surgical risk are reduced by half. Fat accumulated in certain parts of the body, such as the thighs or abdomen, is aspirated through a tube or cannula, which is inserted through a small incision in the skin of about six millimeters. To avoid pain and possible bleeding, a solution containing a local anesthetic and vasoconstrictor medications is administered to the treated areas.

Liposuction involves potential side effects such as scarring, bruising, swelling, and lumps that appear after surgery and do not completely disappear for several months. While it takes some time for the body to adjust to its new shape, most patients who undergo it are satisfied with the results. The most common risks include the excessive removal of fat present in certain anatomical areas to be treated in a single session on the same day. Therefore, to minimize surgical complications and side effects from overexposure to anesthesia, it should be scheduled with multiple surgical sessions.

However, although uncommon, any type of cosmetic surgery, including liposuction, can have complications. These have included infections, reaction to anesthesia, dehydration, numbness and changes in skin pigmentation, fat or blood clots that can migrate to the lungs and cause death, friction burns, excessive blood loss, serious drug interactions, damage to vital organs, seizures, cardiac arrhythmia, cardiac arrest, and brain damage from anesthesia. (Cuenca-Pardo, 2014, 16)

According to Dr. Fritz Barton, president of the American Academy of Plastic Surgery, there are basically four risk factors when performing liposuction: administering excessive amounts of fluids (which replace the removed fat) and local anesthesia, aspirating too much fat at once, performing multiple cosmetic surgeries on the same patient, and failing to consider the patient's previous health. However, these risks can be minimized by having a clear understanding of the associated risks and benefits, as well as realistic expectations. It is extremely important to choose a cosmetic surgeon who thoroughly evaluates and explains the risks and potential adverse effects to the patient, who has adequate professional training, and who performs the procedure in qualified health centers with state-of-the-art facilities.

The problem with this type of surgery isn't that it's dangerous, but that neither surgeons nor patients take it seriously. There's no such thing as a quick liposuction that can be done during your lunch break. This procedure is as safe as any other, but it has become a combination of greed, ignorance, and carelessness, which is why it happens to the patient, according to Dr. Gerald Pitman, a professor at New York University.

In the United States, one in every 5,000 liposuctions performed in the last four years has ended the life of the patient, according to a report by the American Society of Plastic Surgery and although it is a

easy and safe operation, it is being practiced in increasingly precarious circumstances, due to its great popularity.

8.1.8.-Errors in transfusion medicine

Recently, countries' health services have allocated significant resources to improving the biosecurity of blood transfusions. The so-called transfusion chain runs from donor to recipient. Therefore, infection transmitted through a blood product such as red blood cells, whole blood, fresh frozen plasma, cryoprecipitate, or platelet concentrate, among others, is an increasingly rare occurrence.

The SHOT system, which stands for Serious Hazards of Transfusion, is a transfusion control method used in the United Kingdom to request communication or reporting of serious adverse effects secondary to transfusions, including cases of incorrect blood component transfusion (IBCT), where a blood component is transfused that does not meet specific needs or that should be transfused to another patient. (Stainsby, 2003, 45)

Normally, before a blood transfusion is given, two blood type tests are performed on the patient. The first is performed by the doctor or nurse, identifying the sample taken. The second is done when the blood bank staff themselves visit the patient's bedside to confirm the patient's blood type. When discrepancies arise between the two results, this is one of the most crucial moments to avoid the possibility of a mistake.

There are weak links in the transfusion chain, such as its justification, as well as errors in the request and prescription, these are due to an erroneous or poorly documented interpretation of the results of laboratory tests, the decision to prescribe a transfusion must be based on the existence of clinical symptoms and signs supported by the

Laboratory results. If laboratory test results do not correspond to the patient's clinical picture, extreme caution is required, since if they are incorrect, they may be due to inadequate samples or analytical errors.

Likewise, reports provided by telephone may be susceptible to errors and may refer to a different patient with similar first or last names. Adverse events may also be caused by the physician's failure to provide the laboratory with essential information regarding the patient's transfusion history or special needs, for example, prior detection of alloantibodies or indications for irradiation of blood components.

Errors in blood sampling can occur if test tubes are labeled far from the patient's bedside and the patient's identity is not verified. To avoid this risk, all personnel responsible for drawing blood must be properly trained and, if possible, evaluated.

Laboratory errors in blood banks generally occur because manual techniques for urgent blood typing are inherently unreliable and are associated with potential interpretation and documentation errors. Unless the blood bank is fully staffed 24 hours a day, nighttime transfusions should be limited to clinically justified patients, according to the consensus of most authors.

There are basically two types of situations that can arise during the indication of a blood component and they are:

1.- Error in the administration of the component: This is called an episode in which a patient is transfused with a component that does not meet the ideal requirements or that was intended for another patient.

2.-Incident without effect or near-incidents: It is understood as any error, which if not detected in time, would have produced an incident in the

transfusion process, but when detected before the blood transfusion is avoided.

Severity categories of medical errors in transfusion medicine: Severity 0: No clinical manifestations.

Severity 1: Immediate signs without life-threatening and complete resolution of the health status.

Severity 2: Immediate life-threatening signs. Severity 3:
Long-term morbidity.
Severity 4: Data regarding severity are not available or could not be collected.

Post-transfusion immunological reactions:

Reaction	Immunological	Non-immunological
Immediate	• Immediate hemolysis • Anaphylaxis • Urticaria • Feverish reaction • Acute lung injury	• Bacterial contamination • Non-immune hemolysis • Citrate overload • Volume overload • Potassium (K+) overload
Late	• Delayed hemolysis • Post-transfusion purpura • Graft-versus-host disease • Immunomodulation	• Transmission of infections • Hemosiderosis

Source: Taken from Stainsby (2003,75) and modified by us

Causes of transfusion errors include: failure to provide voluntary informed consent, authorization of blood that is not properly registered or of an ABO or Rh group different from the patient, failure to recognize the adverse effects of transfusion of blood products, use of poor heating techniques for blood products such as microwave ovens, direct fire or ovens above 41C°, failure to transfuse a blood product within the first 4 hours, which causes contamination by bacterial growth. Administering red blood cell and platelet concentrates at the same time, use of blood products if the patient does not meet the criteria, inadequate management of fluids and blood products in susceptible patients such as patients diagnosed with heart failure, newborns, and kidney patients. Failure to monitor the

patient during transfusion, authorization and administration of blood products that have passed their expiration date (expired), failure to take into account the patient's underlying pathologies. Among the accidents, we can mention the transmission of diseases, such as relevant viruses: HIV-1, Hepatitis A and B viruses, Hepatitis E, among others.

8.1.9.-The discussion of medical errors

In medicine, the recognition of medical errors has been slow to be recognized, as it encompasses both healthcare professionals and public and private systems. In some countries, such as the United States, conferences are held on the impact of medical errors on morbidity and mortality. (Gallagher, 2003, p. 1001)

Consequently, discussing errors is a goal for learning from and preventing them. Openly discussing the occurrence of errors allows for greater awareness, improved health quality, and patient satisfaction. Similarly, failures in the health system must be improved or corrected. (Orlander, 2002, 1001)

Now, regarding the question: Should the error be discussed with the patient? Many factors can inhibit a medical professional from reporting a medical error, ranging from fear, fear of damaging their reputation, and many other potentially uncomfortable situations. However, revealing an error and taking appropriate measures can prevent further occurrences. Conversely, concealing it undermines trust between doctor and patient and exacerbates its occurrence. (Kaldjian, 2008, p. 717)

Below we will point out an investigation carried out by Gallagher, Garbutt and Waterman, who evaluated some attitudes of both doctors and patients in relation to medical errors, and where three aspects were considered: 1.) What are the attitudes of patients in relation to the commission of errors by doctors? 2.-) Should

Doctors should discuss with patients or reveal to them the commission of an error? 3.-) What are the emotional needs of patients and doctors when a medical error occurs and what solutions should be found? (Gallagher, 2006,116)

Comparison of the different attitudes of doctors and patients towards a medical error:

Topics to focus on or discuss in a group	**Attitudes of the sick**	**Doctors' attitudes**
Definition of error	Discuss unpreventable adverse events, deviations in health care, poor quality of service and poor interpersonal relationships of the doctors. Open attitude.	Closed attitude, only discussing deviations from care standards is acceptable.
Which errors mustreveal oneself to the sick?	All errors that cause harm must be revealed.	Errors that cause harm should be revealed, except if they are trivial or irrelevant and could create more problems than benefits.
Talking about forgetfulness	Mixed positions	There should be no discussion about medical oversights.
That information has toto reveal oneself with respect to the medical error?	Everything must be revealed	The words to be used must be chosen carefully.
How to Reveal Medical Error	Tell the truth and show compassion	Tell the truth, be objective and professional.
Apologize	It is recommended to apologize	Believing that apologizing can make you liable to legal sanctions.
Emotional impact of the error	Fear, anger, frustration and emotional imbalance	Frustration. Desire to understand the damage and its impact.

Taken from (Gallagher,2006,116) and modified by us.

Patients generally agree that they would like to know about errors that cause them harm. They want to know how and why they suffered, the implications for their health, and how to correct and prevent them in the future. Although they want to know quickly, they accept that sometimes obtaining information about the cause of the error and how to prevent it can take time.

Psychologically, patients describe a wide range of emotional responses after a medical error, such as sadness, anxiety, depression, anger, annoyance because their hospital stay is prolonged, and frustration because the error could have been prevented. However, it is reported that doctors also experience strong emotions after having had it.

committed. There is a very stressful moment that begins from the moment the error is committed until the moment when it must be spoken to a patient, as it may give rise to a potential lawsuit. (Blendon, 2002, 347)

8.1.10.-Error compensation

There are various undesirable situations that can arise in the practice of medicine that can give rise to compensation for errors. These situations require the physician to empathize and conduct a thorough review of the errors to demonstrate what actually happened. The patient will need an apology and possibly also financial needs to be covered. A plan must be outlined for the patient and their family members to ensure that this error does not happen again in the future. A letter of apology can be written or different ways to honor the patient's memory can be explored. Likewise, if a lawsuit is filed, one of the demands of the patient or their family members will be financial compensation for the damages suffered, the disqualification of the physician from practicing, and any moral damages caused. (Hampton, 2006, 196)

Summary diagram of some of the factors involved in the consolidation of medical malpractice:

FACTORES EXTERNOS
IMPUNIDAD (ausencia de investigacion y castigo)
ESTADO DE NECESIDAD (Ante ausencia de recursos o insumos)
FUNCIONAMIENTO DEFICIENTE DE COMITES DE BIOÉTICA (En su función preventiva vigilancia y control) en sectores público y privado
ANOMIA (Ineficacia social de la norma)
COLEGIO MÉDICO (Deontología)
CONSENTIMIENTO VOLUNTARIO INFORMADO (Defectuoso, con vicios)
ERRORES MÉDICOS (Por falta de insumos incerteza diagnóstica)
CORRESPONSABILIDAD (Instituciones públicas y privadas)
MISCELÁNEOS (Tecnología, violencia sanitaria, pobre educación del paciente, entre otros)
CAUSAS DE MALA PRAXIS MÉDICA
FACTORES INTERNOS
DESHUMANIZACIÓN DEL ACTO MÉDICO (Presencia del currículum oculto en la educación médica)
BIOÉTICA (Formación deficiente, falta de preponderancia del aspecto ético en los pensa de estudio universitarios)
MERCANTILIZACIÓN DE LA PROFESIÓN (Factores económicos, vanidad, relativización de codigos morales sociales)
OMERTÁ, Códigos de silencio (Sentido errado de la solidaridad en el gremio médico)
FALLA EN LA FORMACIÓN MÉDICA

Source: Own creation

CHAPTER IX

PREVENTIVE ASPECTS OF MEDICAL MALPRACTICE

Medical malpractice is a problem that has been present in societies since the dawn of humanity. It is related to any act or negligence on the part of a healthcare professional that causes harm to the patient. It is important to note that, although healthcare professionals are expected to have adequate training and experience to perform their work safely and effectively, it is also the patient's responsibility to take preventive measures to avoid malpractice. In this section of our thesis, we aimed to address the most salient preventive aspects.

An important tool in preventing medical malpractice is a patient's medical history. Therefore, healthcare professionals should keep detailed and up-to-date records of all medical conditions, as well as any medications or treatments they may have received in the past. This can help prevent errors in diagnosis or treatment, as well as ensure that patients do not undergo unnecessary surgeries.

Another preventive measure is educating patients about their own health and how they can become preventive agents. To ensure this, they must be sufficiently informed about the potential risks and benefits of any medical procedure before making an informed decision about their medical care. Furthermore, patients should be alert to any unusual symptoms or side effects after treatment so they can inform their physician as soon as possible.

Regarding medical specialties, there are additional specific preventive measures. In surgery, for example, it is always recommended to use minimally invasive surgical techniques whenever possible and avoid unnecessary surgeries. Infectious disease must always ensure adequate preventive measures are used to prevent the spread of infections in patients. Anesthesiology must be performed by a

A trained and experienced anesthesiologist is trained to prevent errors in medication administration, performing a thorough preoperative evaluation, and monitoring both during the surgical procedure and in the recovery area to avoid dangerous situations that could endanger the patient's life.

Preventive medicine, which aims to conduct early disease screening and regular medical checkups, are other important measures to prevent medical malpractice. This includes regular medical checkups, a healthy diet, and regular exercise, among other recommendations. Furthermore, it is important for medical professionals to receive adequate socialization to improve their communication skills with patients and reduce the risk of errors in diagnosis or treatment.

In cases where medical malpractice is suspected, the legal process can be daunting for affected patients. Media stalking can be a useful tool to put pressure on the medical professionals involved and ensure a fair resolution of the case.

Bioethics also plays an important role in preventing medical malpractice. Medical professionals must adhere to ethical principles that ensure their actions do not cause unnecessary harm to patients.

In summary, there are many important preventive measures that can help avoid medical malpractice on the part of the physician, institutions, and the patient.

9.1.-Medical history as a preventive tool

In the medical-legal and ethical context, the medical record takes on its greatest significance, as it is the document that reflects not only medical practice but also the fulfillment of the primary duties of healthcare personnel, becoming documentary evidence that assesses the level of quality of care in cases of liability claims against physicians and institutions. It records the entire relationship between healthcare personnel and the patient. It is prepared with the purpose of facilitating patient care. It constitutes a basic element of good healthcare practice because it allows the physician to have a complete picture of their patient and conduct research on pathologies and publish publications of scientific interest. It acts as a faithful reflection of the doctor-patient relationship. It is a public or semi-public document, with limited access rights. It can be considered a record of medical care. It also has the value of evidence in medical liability cases, allowing verification of compliance with the duty to inform. It is a key expert opinion tool for preparing medical-legal reports regarding medical-professional liability.

Failure to comply with or complete a clinical history may lead to the presumption of clinical-care malpractice due to non-compliance with legal regulations, defect in the management of health services, risk of increasing liability for damages to the patient, the institution and the administration, as well as objective medical-legal risk due to the lack of essential evidence in claims. (Lopez, 2004, 1)

Although the ownership of medical records has been a hotly debated issue because it encompasses legally protected rights and interests, the doctrines regarding ownership are highly varied, with the latter being: ownership of the physician, ownership of the patient, ownership of the institution, and integrated theories. Due to current technological advances,

The information contained in medical records endangers some of the patient's fundamental rights, such as privacy and confidentiality.

9.2.-Prevention in the various medical specialties 9.2.1.-

Surgery

All medical specialties are susceptible to errors, however, one of the most likely to occur is surgery. This is because during surgery, several factors are involved that require strict monitoring and surveillance. These include, in addition to the patient, the surgeon, anesthesiologist, instrumental and circulating nurses, and the surgeon's assistant. Conditions of asepsis and antisepsis, administrative issues, and equipment operation are necessary to fully guarantee the performance of the surgical procedure. (Kumar, 2008)

9.2.2.-Unnecessary surgeries

The indication of a surgical procedure to resolve a medical problem is only justified when the condition has no less invasive solution and will provide the patient with a better quality of life, improved functional capacity, or relief from ongoing pain. However, the surgical decision may be made without a thorough evaluation and an accurate diagnosis, which would increase the risk of exposing the patient to a risk. (Leape, 1992, p. 363)

9.2.3.-Infectology

Infections can occur during prolonged hospital stays, but they do not necessarily involve medical error. They can and are preventable if healthcare personnel take preventive measures such as handwashing and sterilizing equipment. In the United States, 80,000 deaths annually are attributed to nosocomial infections. (Burke, 2002, 651)

9.2.4.-Anesthesia

Any error that is permissible in other medical specialties can become a tragedy in the field of anesthesiology. Frequently, the most common medical errors in this discipline include errors in the dosage of the anesthetic to be administered. This can occur when a particular drug is mislabeled, resulting in the administration of an incorrect dose: too little or too much, and the rate of infusion of the substance into the body is also relevant. Other causes of errors include delayed post-anesthetic recovery, failure or damage caused during intubation, and inadequate patient monitoring.

The withdrawal of the anesthesiologist from the operating room has given rise to various legal actions, among which stands out a sentence where the surgeon was reproached for allowing the absence of the anesthesiologist, the judge expressed that since the surgeon knows and consents that the anesthesiologist was absent from the operating room to attend another operation in the hospital, without having previously connected the electrocardiographic control monitor to the patient, the latter suffered a lack of aeration that caused hypoxia, the surgeon belatedly noticing the critical condition of the patient due to the darkening of the blood flowing from the surgical wound, so the appellant ordered to call the anesthesiologist, who upon arriving found the patient in a state of cardiac arrest, resuscitation efforts being useless. The court of that country considered the conduct of the hospital director equally inappropriate, adding that "the existence of fault on the part of the appellant arises from the conduct required of him in his dual capacity as physician and director, who should not have allowed this dangerous and habitual practice of neglect and lack of proper control and supervision of anesthesia physicians." (Yepes, 2003, 3)

The anesthesiology specialist is responsible for monitoring the level of consciousness during the procedure and should not leave the patient's bedside.

their patient, since this requires constant attention. Regarding the issue of immediate postoperative surveillance, there is debate about whether the responsibility lies with the surgeon, the anesthesiologist, the service, or the nurses and the institution itself, for which each specific case would have to be examined. Situations such as turning off the saturation monitor alarm, providing an inappropriate amount of oxygen during surgery, the anesthesiologist being under the influence of drugs or alcohol during the procedure, using defective equipment, or applying dangerously prolonged sedation should not be permitted, since all of this can lead to extremely life-threatening situations for the patient and culpable events.

As preventive measures, each drug should be carefully labeled and tagged, clearly indicating the contents of each ampoule. Organizing the ampoules, including their position and separation in the cabinet, separating potentially dangerous drugs and classifying them by reviewing each medication with the help of another person to prevent errors during administration. In the event of a mistake in administering a medication, this should be reported in a logbook designed for such eventualities. Taking inventories and checking expiration dates are also useful to avoid errors, as is providing a barcode, color identification for each medication, and its generic name. Following operating protocols, maintaining a vigilant attitude throughout the procedure, and carefully reflecting before making each decision in a medical act are key factors in avoiding errors. (Wheeler, 2005, 257)

To recap, some consequences resulting from errors in anesthesiology are: tracheal damage, asphyxia due to inadequate oxygen supply, cardiac damage that may be complicated by acute myocardial infarction, neurological defects, loss of function or mobility of a part of the body,

partial or general paralysis, brain damage, spinal cord injury, loss of sensation in some part of the body, various types of coma and even death.

9.2.5.-Transfusion medicine

The consensus on transfusion medicine indicates the following preventive measures:

1. Have a good patient identification system, including labels, tags, organization, classification, and if possible even a barcode, checking and updating product inventory, and disposing of expired products.

2.- Combat misinformation among Blood Bank staff and medical personnel so that better healthcare work can be achieved through feedback and teamwork.

3.-The use of pre-printed labels and automation optimizes time and prevents patient identification errors.

4.- Hemovigilance, monitoring of high-risk patients, those who have received multiple transfusions, or those who have had an incident.

5.-Have a computer network that allows for rapid service delivery and links with other health centers.

6.-Always request informed voluntary consent prior to all transfusion and exchange transfusion procedures, in compliance with Blood Bank regulations.

7.-Know and be aware of the possible consequences or adverse effects of a transfusion.

8.-Respect the established time between several transfusions or blood products in the same individual.

9.3.-Prophylaxis of errors and medical malpractice

We mention some considerations that may be useful:

1. Never lie. Record all the facts in your medical record exactly as they happened. Explain what happened to the patient and their family without altering the truth.

2. Be prudent. Caution should be one of the pillars of good medical practice. If you are unsure about the dangers of a test or medication, seek help from a colleague with greater experience, knowledge, or seniority. Similarly, case discussions and anatomical-clinical meetings are highly valued.

3. Acquire expertise and skill. Physicians must be adept at performing differential diagnoses and invasive procedures. If they feel unsure or have doubts about a diagnosis, treatment, or approach, they should put the patient's benefit before their own ego and consult with colleagues with proven track records in matters that are unknown or lacking in experience. 4. Adopt a diligent, responsible, prudent, and assertive attitude with patients and colleagues. Communication and discussion of cases with the team are important.

5.- Record keeping. Prepare a complete medical history, outlining all procedures, reporting all relevant data on signs and symptoms, laboratory tests, imaging studies, biopsies, consultations, and differential diagnosis. All of this will allow for the organization of useful information to determine the patient's definitive diagnosis and treatment.

6. Recognize limits and capabilities. This means that the physician must abandon his arrogance and admit his ignorance when he doesn't know or can't address a patient's or illness's needs.

7.-Improve the quality of public and private health services.

8.- Implementation of Bioethics Committees in clinics and hospitals to discuss problems of medical error and malpractice, as well as to design preventive strategies according to the health institution's strengths and weaknesses.

9.-Inform patients about the characteristics of the medical procedure. Promote and maintain a friendly and respectful relationship with the patient and their family. 10.-Regarding the attitude towards an error or unforeseen situation, it should be admitted as soon happens, report it, No hide it, communicate it with he bossimmediately superior, take corrective or preventive actions to avoid potential consequences, prevent falsification, data tampering, and the disappearance and theft of documents. After an undesirable outcome, a serious and responsible explanation must be given as soon as possible to the victim and their family members regarding the causes and factors that led to it and the measures to be taken to reverse or correct it.

11.-Do not overvalue new techniques or instruments. Remember that absolutely nothing replaces a thorough medical history and physical examination to arrive at an accurate and correct diagnosis.

12. Patients must be educated and informed. Except in cases of life-threatening emergencies or in cases of arrival at a health center with a deteriorating state of consciousness or vital signs, before visiting or consulting a physician, they should request references and information about their moral and ethical suitability, as well as their competence in the area or discipline for which they claim to be qualified. Except in cases of war or catastrophe, health personnel should not be allowed to practice their profession in conditions that are inadequate or undignified for professional practice.

13.-The physician should refrain, as far as possible, from diagnosing, prescribing, suggesting, or indicating treatments by telematic means (telephony and computer), remotely, or through third parties. (Leape, 1993, 144)

14. Avoid defensive medicine, safeguarding the doctor-patient relationship, as well as demanding respect for their profession from journalism and condemning sensationalist press.

15.-Refuse to participate in unhealthy or defamatory comments among

colleagues, especially in the presence of patients and third parties.

16.-Know and faithfully comply with existing guidelines, codes, and regulations.

17.-Protect the records to avoid losses, theft of pages, corrections and other situations that diminish their value as evidence.

18. Demand the necessary equipment to ensure proper medical practice and report unhealthy conditions in healthcare centers and personal insecurity, in order to achieve better healthcare delivery.

19. Never abandon the patient. 20.

Maintain professional confidentiality.

As a summary table, Dr. Arteaga Sánchez's recommendations to avoid medical malpractice lawsuits are provided:

1.- Act at all times for the good of the patients and never for the harm of anyone else. Primum non nocere.
2. Self-sufficiency can be your worst enemy. Consult with other colleagues and recognize your own limitations.
3.- Educate every patient about the characteristics of the medical procedure, diagnosis or treatment and request their informed consent.
4.-Do not consider yourself infallible, nor speak ex cathedra.
5.- Warn patients about the risks of medical treatment and emphasize that medicine is not an exact science.
6.-Do not forget that your obligation is one of means and not of results.
7.-Don't overemphasize the latest in medicine or cutting-edge technical approaches. Each case has its own unique requirements.
8. Value common sense and logic as diagnostic tools and part of treatment. 9. Immediately admit mistakes made, which does not mean admitting imprudence, negligence, or incompetence.
10.-Do not overvalue techniques or instruments, nor put them before the direct and human doctor-patient relationship.
11.-Do not blindly trust the skills of members of a medical team, colleagues or paramedics.
12.-Do not criticize the diagnosis or treatment of other doctors.
13.-Do not act without the minimum required means and instruments and promptly report hospital deficiencies.
14.-Keep a written record of what has been done, respecting confidentiality and professional secrecy.
15.- Endorse interventions that affect privacy with auxiliary technical staff or with people the patients trust.
16.-Do not consider the patient a potential whistleblower. They are an ally in restoring your health.
17.-Dispense with remote indications, diagnoses or treatments, except in emergency cases.
18.-Be clear that for each patient, their case is the most important
19.- Become aware that the medical profession is an apostolate that demands a vocation of service 20.- Practice enzymatic medicine, that is, be on top of the patient.

Source: Mimeographed material borrowed from Dr. Alberto Arteaga Sánchez.

9.4.-The patient as an active agent in the prevention of medical malpractice

Patients should be involved, informed, and aware of their rights. They should consider choosing a hospital with experience in their condition or illness, avoiding clandestine centers that lack the proper operation and infrastructure to handle emergencies or unforeseen situations. They should request information about the procedure to be performed, as well as its potential complications, risks, and consequences, the existence of other therapeutic alternatives, and the choice of their treating physician. Upon discharge from the healthcare institution, patients should request instructions, treatments, written instructions, and recommendations to follow at home. They should also delegate a family member, representative, or other person to act as their advocate if they are unable to make decisions for themselves, or if they are at risk of losing consciousness or entering a coma. (Vidal, 2013, 175)

The general population does not easily accept that, regardless of the severity of the patient's condition or the interest and resources employed, a satisfactory result is not obtained, and in this case, some people desire to seek compensation, at least financially. Furthermore, the relationship between medical conduct and the usual standard norms for a specific case presupposes the existence of protocols, clinical guides, or specific health regulations that can justify and protect the medical procedure followed. These regulations will be more widely recognized if they are endorsed by a national or regional scientific society, or at least by a hospital committee. (Leape, 1998, p. 1444)

Medical errors unfortunately lead to a loss of confidence.In the health system and at high costs for the State, patients with long hospital stays, who have suffered some harm or disability as a result of a medical error, usually present psychological alterations, while

Healthcare professionals display frustration and loss of morale when they make a mistake. Among the proposed strategies, it is suggested to establish medical protocols, work tools, safety systems for the execution and review of procedures, leadership, and knowledge of biosafety systems. Errors should be identified and learned from, and organizations should be promoted for the development of strategies and preventive measures. Discussions facilitate professional learning for physicians and provide emotional support after these types of events. The taboo culture that exists in the medical profession regarding this topic should be eliminated, as these can be aired in anatomical and clinical meetings and medical boards. However, little research has been done on this topic (Vicent, 2003, 76).

In this regard, Lauris Christopher Kaldjian, an ethics expert, conducted a survey among faculty and residents at several hospitals located in the Midwest and Northeast of the United States to investigate attitudes and practices regarding discussions about mistakes, hypothetical errors, the experience of error role modeling, and demographic variables. He found that out of 338 physicians, only 73% agreed to participate, indicating that they often talked about their errors with their colleagues, 70% thought that discussing errors strengthened professional relationships, and most knew at least one colleague who would be a supportive listener. Among the motivations for discussing the error were concern about whether another colleague would have made the same decision (91%), learning from the mistakes of other colleagues (80%), and the desire to receive support (79%). (Kaldjian, 2008, 717)

9.5.-The socialization of medicine in the prevention of medical malpractice

Medicine is a discipline that has become one of the most important professions in our society, the work of doctors and their work cannot be underestimated, since they are the ones in charge of maintaining the

human life and the health of the population. However, in recent years, the concept of medical malpractice has become increasingly common in the field of medicine. This term is used when doctors fail to meet medical care standards or even make mistakes that can harm the health and well-being of their patients. An interesting question many are asking is whether the socialization of medicine could reduce medical malpractice.

The socialization of medicine refers to the democratization of access to medical services for the entire population, ensuring universal and equitable access to health care. Significant steps toward the socialization of medicine have already been taken in some countries, primarily through the creation of state health insurance systems. By socializing medicine, the goal is for all patients to receive the medical care they need, regardless of their economic status, race, gender, or any other variable. This would mean more resources and personnel available to care for patients, thereby reducing workload, stress, and pressure on physicians.

Medical malpractice can have serious consequences for patients, ranging from negative medical outcomes to a loss of trust in the health care system. Some suggest that one possible solution to reducing it would be the socialization of medicine. That is, if all patients had access to high-quality, universal, and equitable medical care, physicians could focus on working more efficiently and with less pressure, rather than worrying about the profitability and cost of their services. Physicians would work to ensure patients receive the care they need. Perhaps there would be greater accountability among physicians if patients were assured access to multiple medical providers.

The results of medical socialization are not always easy to measure; medicine is a comprehensive and complex science, where many variables and factors influence medical outcomes. Furthermore, the problem of medical malpractice is not only due to a lack of resources; it can also be caused by poor training and a lack of accountability among physicians and healthcare personnel in general. While medical socialization could provide some benefits, it would still require oversight of medical work and rigorous standards.

9.6.- Media persecution in the prevention of medical malpractice

Medical malpractice is a global problem that causes pain and suffering to thousands of people regardless of age, race, sex, or social standing. Media stalking is a commonly used strategy to expose malpractice and achieve greater accountability and transparency in the medical field. Regarding the reasons for and against the idea that media stalking could reduce medical malpractice, we present the following: (Torres, 2018)

The reasons for media stalking as an effective way to reduce medical malpractice:

1. Public exhibition

Media harassment could publicly expose a doctor or healthcare institution that has committed serious medical errors, potentially causing significant damage to the reputation of the institution or the doctor. This would result in doctors being more careful and responsible in their medical practice to avoid future negative public exposure.

2. Pressure and responsibility

Media pressure could lead to accountability for the doctors, hospitals, and institutions responsible for the incident. Doctors may feel

pressure from public opinion and the media to be more careful and responsible in their medical practices.

3. Greater transparency

Media prosecution could help provide greater transparency in health management, as public disclosure of medical errors would allow the public to better understand problems within the health care system, which could help improve the quality and safety of health care overall.

Reasons against media persecution as a way to reduce medical malpractice:

Media hounding may not be effective in reducing medical malpractice for the following reasons:

1. Sensationalism

Media persecution could be sensationalist or yellow journalism and damage the ethics and honor of both the medical professionals and the institutions involved. This could perhaps be unfair and fail to provide an adequate assessment of the circumstances surrounding the medical error, as it is a pronouncement prior to the elucidation of the facts.

2. Lack of medical knowledge

Journalists covering medical malpractice stories may lack sufficient knowledge of medicine and its complexities, or of the workings of the healthcare system. A lack of medical knowledge would make it difficult to identify the details of each particular case and lead to an inaccurate, biased, and unfair assessment. Furthermore, journalists would likely lack access to crucial information during the investigative phase necessary to accurately assess the case.

3. Fear of denunciation

Media persecution could cause doctors to be afraid of undertaking certain medical practices or risky procedures, even if it is

necessary to save the patient's life. Furthermore, some doctors fear being sued for minor medical errors, which could negatively affect their practice.

As with any multi-causal and complex problem, media stalking may be effective and helpful in some cases, but inaccurate and harmful in others. Medical malpractice is a problem that must be addressed seriously and responsibly by establishing effective systems of accountability, transparency, and quality control in healthcare, which would perhaps provide a more effective way to reduce it than media stalking. Therefore, media stalking should only be seen as a tool in exceptional cases and in very serious situations.

9.7.-Bioethics in the prevention of medical malpractice

One of the primary goals of bioethical standards is to protect the rights and well-being of patients, as well as to establish limits and regulations for medical practice. Medical malpractice is a violation of these standards, which can have devastating consequences for patients. Bioethical standards are based on fundamental principles such as patient autonomy, nonmaleficence (do no harm), beneficence (benefit), justice, and equity. These principles establish the foundation for quality medical care and are used to determine whether a physician's conduct is acceptable. Furthermore, they also define the rights of patients to receive quality medical services and establish the duties of physicians to provide them.

The existence of these bioethical standards does not mean that malpractice does not occur. However, the standards provide a framework that allows physicians who violate ethical principles to be identified and penalized. The standards also serve to educate physicians about what is and is not permitted in their practice.

The adoption of bioethical standards has been an important factor in reducing medical malpractice. In many countries, medical practices are regulated by government entities, such as medical and nursing councils, which establish ethical standards and regulations. Furthermore, healthcare institutions, such as hospitals and clinics, often have internal protocols and policies to ensure that medical care meets ethical standards. It should be emphasized that bioethical standards cannot completely eradicate malpractice, as it may be hidden or difficult to prove. However, by establishing an ethical and legal framework, standards can help reduce the incidence of malpractice and ensure that patients receive quality and safe medical care.

Bioethical standards have proven effective in controlling and prohibiting medical malpractice. While ethical violations can occur, the standards provide a framework that establishes boundaries for medical practice and penalizes physicians who violate these boundaries. The standards also educate physicians and healthcare institutions about ethical standards for quality and safe medical care. Ultimately, bioethical standards are essential to protecting the rights and well-being of patients and ensuring ethical medical practice.

9.7.1.- Legalization of bioethics as a preventive tool for malpractice

In the opinion of Valdés (2014,2) "...it is stated that bioethics, in its non-binding deliberative structure, is insufficient to point out jurisprudential and doctrinal precedents to design a binding regulatory framework for biomedicine, specifically with regard to non-therapeutic genetic manipulation. One of the most important reasons why bioethics has difficulties in generating binding regulatory frameworks for biomedical practices is that the principles of biomedical ethics have been

defined by Beauchamp and Childress as principles of common morality, which, although it may seem paradoxical, makes their application very difficult. Therefore, the understanding and use of the principles often differs depending on who applies them."

Beauchamp and Childress (2001, 67) provide some key elements for deciphering what a correct application of principlism would be, although they initially err in considering that one of the central elements of deliberation should be what they call common morality. We can call common morality the set of norms shared by all those committed to morality.

This is not merely a morality, in contrast to other moralities. Common morality is applicable to all people everywhere, and we can correctly judge all human behavior based on these standards. Therefore, the justification and legitimation of the four prima facie principles of biomedical ethics rests on the shared judgments of all those committed to morality. In this way, common morality—understanding "common" as "universal"—is the starting point and, at the same time, the condition of possibility for reaching agreements regarding conflicts of values, interpretations, and assessments in the clinical and biomedical fields. (Valdés, 2014, 3)

However, what Beauchamp and Childress claim is at least dubious, for several reasons: 1. Common morality is not truly universal, since people generally share principles conceptually, that is, they do not agree on their contents. Thus, almost everyone committed to morality will agree that the principles of autonomy and justice are morally plausible and acceptable, but they will not necessarily share their meaning. This detail, which shows that the principles of common morality are shared only formally, represents a serious obstacle to the

decision-making in bioethics and can paralyze deliberation. 2.) The principles of common morality are too vague or abstract to adapt to the specificity of moral problems and controversies, which, therefore, require more concrete norms for their resolution. 3.) The hierarchy of specific and concrete norms is procedurally simpler and more useful for deliberation than attempting to rank principles with diffuse and ambiguous meanings. 4.) The agreement regarding the status of rules is explicit since it requires reasoning at the content level; the consensus on the relative value of principles is only tacit, since it expresses only a concordance of intuitions and concepts. Since moral and also legal controversies indicate an explicit conflict of content, it is clear which agreement is methodologically more useful for decision-making. 5.) Since principles are norms of common morality, they should imply categorical obligations (absolute and unconditional). (Valdés, 2014,3).

However, even the seemingly most binding rules (do not kill and do not harm) would allow exceptions depending on the legal framework of each country. This reveals that the purported universality and applicability of common moral principles would be controversial and open to discussion.

We believe that the legalization of bioethics is a very complex issue that has generated various debates within the medical community. It would involve establishing laws and regulations governing medical practice, which could have both benefits and disadvantages.

One of the main benefits of the juridification of bioethics would be the protection of patients and the prevention of medical malpractice, since by establishing clear laws and regulations on the rights and duties of physicians, compliance with ethical standards would theoretically be guaranteed.

in healthcare and this would provide a legal framework that would allow patients to seek justice if they have been victims of malpractice.

Likewise, the legalization of bioethics would promote equality and equity in health care by establishing legal criteria for difficult medical decisions, such as the initiation or withdrawal of intensive treatment, avoiding discrimination and ensuring the impartial and fair evaluation of cases.

However, the excessive juridification of bioethics can also have some disadvantages. First, there is a risk that, due to the inherent complexity of medical practice and the existence of ethical dilemmas, it could be reduced to a simple series of rules and procedures, losing focus from an ethical perspective. This would lead to bureaucratic medical care that is removed from the doctor-patient relationship. Second, the juridification of bioethics could also generate fear and uncertainty among health professionals, since the strict application of laws and regulations could lead to defensive medicine, where doctors feel compelled to perform unnecessary treatments or avoid making difficult decisions for fear of potential lawsuits.

Ultimately, the juridification of bioethics has benefits in terms of patient protection and promoting equality in healthcare. However, it is important to strike a balance between legal regulations and space for ethical reflection and professional decision-making. Excessive juridification could have negative consequences, such as the bureaucratization of medicine and fear among healthcare professionals. Therefore, it is essential to find a balance to ensure ethical and legally sound medical practice.

9.7.2.- The inadequacy of bioethics to resolve conflicts

The principle of respect for autonomy establishes self-determination as a general rule, and for this capacity to be verified in procedural terms, certain well-defined rules in bioethics must be met, such as information, understanding, intentionality, will, conscience or lucidity, the absence of external coercion, and the possibility of a surrogate decision. However, Valdés (2014,4) clarifies that some of the criteria could collide with each other; for example, from a utilitarian perspective, the utilitarian metacriterion of moral correctness would collide with the principle of respect for autonomy, such as sacrificing a marginal minority in order to benefit the majority. There are several levels of morality at play: theories, principles, and rules that collide in a multifactorial synthesis. All of them point to three central problems for deliberation: 1) The conflict itself, already intrinsically complex, 2) The presence of varied positions and arguments to defend one or another course of action, and 3) The absence of sufficient argumentative evidence to accept, simply, any of them over the others.

9.7.3.- The principles of biolaw

The principles of biolaw were officially published in 2000 in the book Basic Ethical Principles in European Bioethics and Biolaw by Jacob Rendtorff and Peter Kemp, Danish academics who attempted to create a theoretical framework for what was then nothing more than a neologism. Their task was to give biolaw a disciplinary character, but it remained nothing more than a legal iteration of the principles of biomedical ethics. These principles—Autonomy, Dignity, Integrity, and Vulnerability—were the result of the European Commission's Biomed II Project: Biomedicine and Health Research. The general framework of the principles was designed from an original proposal by Peter Kemp, who served as the coordinator of the aforementioned project.

project. When asked why these principles and not others, the authors point out that their choice expresses an effort to justify the protection of human beings in the context of rapid development in biomedicine and biotechnology. In this sense, autonomy, dignity, integrity, and vulnerability emphasize the condition of the human being as an end in itself and an individual capable of self-determination. (Valdés, 2014, 2)

In Valdés's opinion (2014,4), it would not be necessary or advisable to legalize bioethics, since the principles of biomedical ethics are abstract theoretical guides of common morality that, when specified, that is, limited in scope and enriched in content, can guide deliberation at a rather initial stage. In the context of moral reasoning, every principle is a beginning.

Therefore, it would be a mistake to base juridification on the level of abstract norms; a contradiction between two principles of constitutional rank would be enough to remain in aporia, that is, in a kind of deliberative obscurity.

Without legalizing the principles of biolaw, it will not be easy to move toward establishing a legal balance between the enormous possibilities implied in the development of biomedicine and the protection of the right to self-determination, the right to be treated as an end in itself and not merely as a means or instrument for other ends, and the right to be protected from any bodily or psychological harm or injury. The process of legalizing the principles would theoretically be simple, as it would involve specifying them in specific, binding rules. However, biomedical advances imply new therapeutic possibilities and reveal a less promising but morally and legally controversial face (Valdés, 2014, 5).

CHAPTER X

CASES SENTENCED FOR MALPRACTICE

10.1.-Cases adjudicated for medical malpractice. Case No. 1: File No. 11-00146 (NBQB), Zulia State.

On June 7, 2002, the 11th Prosecutor's Office of the Public Ministry of Zulia State received a complaint filed by Maritza Stella Escobar Ariza, holder of identity card No. v.-3,637,617, in which she states that on February 18, 2002, she was evaluated at the Zulia State Clinical Hospital by Dr. Cesar Alberto Cobarrubia Rador (traumatologist) for severe gluteal pain radiating to her spine and right leg. After examining her, Dr. Cobarrubia diagnosed a herniated disc in the L4-L5 segments of her spine. Additional studies were ordered, and on February 6, 2002, she underwent surgery at the San Rafael Home Clinic in the same state. During the operation, she suffered a tear of the epidural sac in the dura mater, which caused a loss of cerebrospinal fluid. She remained on complete bed rest for 3 weeks, at the end of her rest she began to feel the same initial symptoms, which is why she consulted Dr. Cobarrubia again, however, he told her that everything was due to the post-operative inflammatory process and sent her to rehabilitation; however, as all the symptoms exacerbated, she had to undergo an MRI of the spine, which reported that the hernia continued in the L4-L5 segments and that Dr. Cobarrubia had operated on the L3-L4 segments and not the L4-L5 segments as he should have. The patient decided to consult the opinion of another expert, Dr. Adolfo Brea, due to experiencing intense and disabling pain in the right lumbosciatic region with external lateral irradiation of the leg on the same side and hallux that incapacitated her from her daily living, work and domestic activities. Dr. Brea diagnosed Lumbar Radicular Compression Syndrome with neurological deficit in the right 5th lumbar root, L3-L4 compression syndrome due to disc prolapse and/or compression by post-surgical adhesions.

On 06/07/2002 she was operated on by Dr. Brea, who performed release of adhesions of the dura mater in segments L3-L4 on the right side, correction

of cerebrospinal fluid cystic bleb, bilateral laminotomy at L4-L5 with medial facetectomies, bilateral discectomy and release or excision of the ligamentum flavum at the L5/S1 segment.

Based on the facts described, in the First Control Court, on January 27, 2005, the Public Prosecutor's Office accused citizen César Alberto Cobarrubia of the crime of Serious Negligence Injuries, provided for in article 422, ordinal 2 of the Venezuelan Penal Code in conjunction with article 417 ejusdem. Based on the documented facts, on October 26, 2009 the Court sentenced Dr. A. Cobarrubia to 6 months in prison plus the accessory penalties of Article 6 of the Penal Code, I quote: "The accessory penalties of imprisonment are: 1.- Political disqualification during the term of the sentence, 2.- Subjection to the surveillance of the authority, for one fifth of the time of the sentence once it has ended, and the accessory penalties of Article 34 of the Penal Code that refer to the payment of procedural costs, such as stamped paper, stamps, compensation and rights previously established by law and other expenses caused in the trial or on the occasion of it, those that are not assessed by law will be determined by the judge with the assistance of a party."

The defendant appealed this ruling to the Third Chamber of the Court of Appeals of the Criminal Judicial Circuit of Zulia State. The Court of Appeals upheld the October 26, 2009, judgment issued by the Court of First Instance for the commission of Serious Negligence Injuries. The Eighth Public Defender of the Zulia State Public Defense Unit filed an appeal against this ruling, acting on behalf of Dr. Cobarrubia.

The Appeal for Cassation before the Supreme Court of Justice, in its Criminal Cassation Chamber, on April 28, 2011, declared the appeal inadmissible, since this sentence is not appealable in Cassation, because the crime of Serious Negligence Injuries provided for in article 422 ord. 2° and that for the

which Dr. Cobarrubia was sentenced did not exceed the maximum limit of 4 years as required by Art. 459 of the Venezuelan Penal Code.

Comment: This case occurred in the State of Zulia was a lawsuit against a doctor for causing serious negligent injuries to a patient during the correction of a herniated disc at the level of the L4-L5 segments of her spine, in said surgical intervention the segments to be operated on were mistaken, and the L3-L4 segments were injured, resulting in a lumbar radicular compressive syndrome, with neurological deficit due to disc prolapse and adhesions, which incapacitated the patient and forced her to reoperation. Faced with this situation, the patient sued the doctor and after nine years of trial, the TSJ in its Criminal Cassation Chamber ratified the conviction of 6 months in prison, plus accessory penalties. It should be noted that nine (9) years had to pass to decide a case that did not withstand a critical and objective analysis to reach the conclusion that this citizen was caused a serious negligent injury that deserved compensation. However, criticism of the slowness with which the justice system generally acts is encouraged by the knowledge that there are cases where the decision is made in accordance with the legal system and justice is applied.

Case No. 2. File No. 203-000246. Aragua State

This case was judicially initiated on January 26, 1996 in the State of Aragua and was decided by Judge Carlos Oberto Velez in the Civil Cassation Chamber. It was a lawsuit for compensation for material and moral damages brought before the Third Court of First Instance in Civil, Commercial and Agrarian Matters of the State of Aragua by citizen José Alberto Navarro Márquez, legally represented by attorney Freddy Hernández, against ophthalmologist Enrique García León, represented by attorneys Julián Isaías Rodríguez Díaz and Raúl Rincón Cabrera. The Superior Court of Civil, Commercial, Traffic, Labor, Job Stability and

Minors of the same Judicial District, hearing the case in a vertical hierarchical function, issued a judgment on October 10, 2002, dismissing the procedural appeal filed by the plaintiff, confirming the ruling of the a quo of January 26, 1996. Against this ruling, the plaintiff announced an appeal, which was admitted by the Civil Cassation Chamber of the TSJ on August 10, 2007.

Case Summary: This was an ophthalmic surgical procedure in which Dr. Enrique García León (EGL) performed an extracapsular extraction of the crystalline lens of both eyes on patient José Alberto Navarro Márquez (JANM), which took place on August 25, 1992 (right eye) and September 1, 1992 (left eye) to correct the opacity caused by cataracts in both eyes. Given the adverse consequences that occurred shortly thereafter, the patient filed a lawsuit alleging that his informed consent was not sought for the removal of his crystalline lenses and that the removal caused the visual disturbances he was experiencing. After the proceedings were concluded, the Court made the following observations:

The reports before the appeal court alleged a violation of Articles 1394 and 1399 (sic) of the Civil Code (CCV) in the appealed judgment due to a false assumption, as it mentioned, analyzed, and assessed two documents issued by the defendant, in which the extraction of the right and left crystalline lenses and the placement of intraocular lenses were transcribed without problems in two prescriptions, without identification or signature. These two documents demonstrated that the defendant did not impose on the patient what was going to be performed, thereby destroying the presumption of informing him. However, the appealed court did not take these allegations and evidence into account.

Likewise, the appealed judgment had been denounced in appeal reports regarding the violation of articles 508 and 12 of the Code of Civil Procedure due to false assumptions, by attributing to the witness Henry Greyner the recommendation as an alternative to internal surgery, when neither in the testimony nor in any other

part of the file had made such statements. The respondent also failed to comment and commits the same error as the appealed judgment.

It was reported that the appealed judgment, when establishing the presumption, did not justify its admission in accordance with the concurrent requirements of seriousness, precision and concordance; it limited itself to pointing out the known fact and inferring the presumption and corroborating it with a single record of the file, incurring in a lack of motivation, article 1,399 (sic) of the CCV. Both the appealed judgment and the appealed judgment incurred in the same vice.

The appealed judgment revealed the negative inconsistency by pointing out the negligence of EGL in failing to report the extraction of the lenses and its subsequent consequences, particularly choreoretinal atrophy in the posterior pole of both eyes, degeneration in the periphery of the right eye, posterior detachment of the vitreous humor, myopic degeneration of the posterior pole and retinal periphery, dislocation of the intraocular lens, opacity of the posterior capsule in the right eye, loss of accommodation due to the extraction of the lens, and anisometropia that impedes binocular vision. The appealed judgment did not expressly, positively, or precisely rule on these arguments. It was alleged that the appealed judgment did not address the defendant's negligence when it stated in the answer to the complaint that: "the weakness of severely myopic patients exposes them to holes, tears, retinal detachment, alterations in the anatomy and transparency of the vitreous humor." It was reaffirmed that the defendant never informed the patient of these risks, or that it was pointed out in the appeal that the damages described in the negligence as elements of the fault are the proven consequence of the defendant's reckless behavior, since the damage was foreseeable due to his status as a doctor.

The lack of prior information and consent was alleged in the complaint, and the defendant never proved otherwise in writing. The defendant attempted to prove this fact with a presumption under Article

1399 of the CCV and the contested decision admits the presumption on the basis that JANM had indicated: “open each eye” so he knew that the lens extraction was going to be performed.

In deciding, the Court observes:

The plaintiff alleges a violation of Articles 1185 and 1196 of the Civil Code due to misapplication. In this regard, the appellant argues that the defendant acted with negligence, recklessness, and incompetence when performing the surgery on the plaintiff's eyes.

It should be noted that Article 1185 of the Civil Code provides three possible hypotheses for configuring extracontractual legal liability: negligence, incompetence, or recklessness. These three possible actions by the agent causing the damage have different meanings and connotations, according to jurist Guillermo Cabanellas de Torres. Negligence is the omission of diligence or care that should be exercised in business, in relationships with people, and in the handling or custody of things; it is carelessness, abandonment, or laziness. Recklessness is generically the lack of prudence, caution, or omission of due diligence. Incompetence is the lack of knowledge or practice required in a profession, art, or trade; it is clumsiness, inexperience.

To be held liable for an unlawful act, the person causing the damage must necessarily act in one of the three ways; more difficultly, it will be possible for them to carry out all three in a single act. Therefore, it is the duty of the person making the formal claim to indicate and establish for this Civil Cassation Chamber which of the hypotheses contained in Article 1,185 of the Civil Code the defendant incurred. Without this, this Supreme Civil Jurisdiction would be prevented from exercising its cassation control.

In this complaint, the appellant points out that the defendant's actions are negligent, imprudent, and inexperienced, and that these three dissimilar behaviors are proven in the records, with

which seeks to prove precisely what must be proven, in addition to the fact that the appellate judge points out in her decision that: "Regarding the evidence of the plaintiff, it is observed that the content of the material and moral damages was not determined, in addition to its evidentiary inactivity to justify its respective statements of fact, with respect to civil liability."

The Court concludes that the appellant intends for the Supreme Civil Court to determine, from the text of the complaint, what the defendant might have encountered; such a choice is beyond the powers or authority of this Civil Cassation Court. The appellant should have clearly and precisely stated the nature of the defect he alleges.

Decision: For these reasons, this Supreme Court of Justice of the Bolivarian Republic of Venezuela, in its Civil Cassation Division, administering justice in the name of the Republic and by authority of law, hereby dismisses the appeal for cassation filed by the plaintiff against the judgment of October 10, 2002, by the First Superior Court of Civil, Commercial, Traffic, Labor, Job Security, and Juvenile Matters of the Judicial District of the State of Aragua. Caracas, August 10, 2007.

The appellant is ordered to pay the procedural costs of the appeal in accordance with Article 320 of the Code of Civil Procedure.

Comment: Eleven years passed during which the victim attempted to obtain compensation for the damages suffered as a result of cataract surgery, without receiving any support from any of the appealed courts. The above ruling highlights the need to establish a good doctor-patient relationship where the patient is sufficiently informed of the risks of a particular technique or procedure through informed consent, preferably written, using clear and simple language.

*lex artis*It is constituted both by acting correctly and by the duty to provide information. This is why it is vitally important to request voluntary informed consent. Failure to do so would be understood as a fault and a violation of freedom of choice.

Case No. 3: Exp. AA20-C-2023-000085 Civil Cassation Chamber. Reporting Judge Henry José Timaure Tapia. Parties: Luis Alfredo Gutiérrez Anzola vs. Yesenia Coromoto Urdaneta Salazar. Case sentenced with compensation for moral damages to a natural person and legal entity.

Our case is before the Civil Cassation Chamber of the TSJ (High Court of Justice), where both the individual and the legal entity were convicted in the lawsuit for compensation for moral damages by citizen Luis Alfredo Gutiérrez Anzola against Yesenia Coromoto Urdaneta and the El Rosario Hospital in Maracaibo, Zulia. A 19-year-old business administration student is undergoing surgery for a deviated nasal septum. During the postoperative period, he is left without an anesthesiologist or vital signs monitor. He goes into cardiorespiratory arrest. CPR is administered, but he is left with motor dysarthria, difficulty speaking, seeing, and walking. The quantum was initially calculated at 500 million bolívares fuertes (strong bolivars). A supplementary expert appraisal was conducted from that judgment and that base amount, and the expert examination yielded a total of Bs 105,785.42. That amount of Bs 105,785.42 was reported as insufficient, requesting a complementary expert opinion of the ruling because a non-current jurisprudential criterion had been applied, contrary to the doctrine and jurisprudence of the Constitutional Court and the Civil Cassation Court, in addition to the violation of the principles: constitutional principle of plausible expectation, legitimate trust, legal certainty, stability of criteria, constitutional guarantees such as the right to petition, equality before the law, due process and the right to defense were violated.

To repair the moral damages, the judge ordered compensation in accordance with Article 1,196 of the Civil Code, proceeding to conduct a supplementary expert appraisal of the judgment with three accounting experts: one appointed by the court, another appointed by the defendant, and a third appointed by the plaintiff, taking into account national consumer price indices and monetary reconversions from the date the claim was admitted.

At that time, the judge declared that the accounting appraisal should be conducted from the date the lawsuit was admitted, that is, from February 2016 to April 2022, based on the amount ordered to be paid; that is, on the sum of 500 million bolívares fuertes, the currency in effect at the time the lawsuit was filed.

The plaintiffs argue that the Court's ruling, in the case of Nieves del Socorro v. Luis Carlos Lara, ordered the court to correct the amount ordered to be paid, but only from the date the ruling was published until its execution.

The judge then reinstated the case by order of June 20, 2022, in which the bases on which the expert opinion would be carried out on the amount awarded in the final judgment of April 2019 were established, determining that the expert opinion should be carried out from the date of admission of the claim (February 2016) until (April 2022) on the amount ordered to be paid, that is, 500 million bolívares fuertes. Since this procedure contradicted the criteria of the Civil Cassation Chamber on how to agree on the indexation of moral damages awarded in a trial, given their particular nature, since they could only be accounted for after the date of the final judgment, the date on which the judgment is published, that is, April 2019, should be used as the starting point for calculating their indexation.

Given that an error occurred in the method of calculating the indexation of moral damages that affected the complementary expert opinion of the ruling and given the detection of a defect in public order with a breach of substantial forms of the process, the Court ex officio overturns the ruling in its entirety, decreeing its absolute nullity and proceeds to decide the controversy according to a new civil cassation process.

Once the wrongful act has been verified, the judge will discretionally determine the amount of moral damages to be compensated to the victim in accordance with Article 1,196 of the Civil Code.

To determine the final amount of damage to be compensated, take into account:

The significance of the damage: The plaintiff has irreversible damage, difficulty walking, speaking and seeing.

Degree of culpability of the author: The anesthesiologist incurred negligence, incompetence or imprudence, as did the El Rosario Mercantile Company, given the employment relationship between both co-defendants, serious negligence of the author of the damage in the present case.

Victim's conduct: The victim did not intentionally cause harm. Moral

distress scale: extremely severe.

Scope of compensation: It is presumed that both the clinic and the anesthesiologist have the financial capacity to honor the compensation.

The details and other circumstances: Motor dysarthria is a very serious condition.

Pecuniary references: In view of restructuring the value of the Petro, it was decided, in substitution of this and the Tax Unit, to replace it with the official exchange rate of the currency of greater value of the Central Bank of

Venezuela, 1,200,000 times the official exchange rate of the highest value currency established by the Central Bank of Venezuela.

Case analysis:

This is a judgment for compensation for extremely serious moral damages in a person who suffered irreversible injuries following surgery. The criteria used by the Court were: the significance of the damage, the degree of culpability of the perpetrator, the conduct of the victim without whose action the damage would not have occurred, the scope of the compensation, and the details and circumstances that influenced the victim's decision to set the amount of compensation for moral damages. In this case, both the natural person, Yesenia Urdaneta, and the legal entity, in this case, Hospital El Rosario CA, were sued; both were convicted. The initial amount to be compensated was five hundred million bolivars, but because Venezuela has gone through different monetary cones and the existence of currency variability and other accounting elements such as the Unidad Tributaria and the Petro, the judge took into account accounting expertise and monetary references to establish the quantum, and decided to set the payment amount according to the official exchange rate of the currency of highest value, established by the Central Bank of Venezuela. This is the jurisprudential criterion in force at the time of issuing the final ruling in the first instance, which presents the peculiarity that the judge will ex officio order in the operative part of the judgment the monetary correction of the amount ordered to be paid, but only from the date the judgment is published until its execution.

However, it is also valid to consider different ways of estimating moral damages in other parts of the world. If we believe in democracy and the role of judges and lawyers in the system, we must apply and explain the law in our decisions. We need

an acceptable criterion for calculating moral damages, something that allows us to make the right decision in each case without having to complete a doctorate in philosophy or mathematics.

Acciarri (2015,210) points out that some time ago there was a dispute between the lawyer Ronald Myles Dworkin about the value of wealth. Ronald Dworkin maintained that wealth was not a value and that -according to him- he would like all judges to be philosophers, while another lawyer, Richard Allen Posner, affirmed that wealth was certainly a value and wished that judges were economists. To settle the controversy between these two brilliant minds, the help of the jurist Guido Calabressi was requested, who intervened in the dispute by pointing out that it would be desirable that "judges were only judges."

In law, abstract assessments often arise, and problems arise when calculating moral damages. What is noteworthy here is that both judges who apply formulas to determine moral damages and those who do not have them have weaknesses in their typical reasoning. However, if we can understand the weaknesses in this reasoning, we would understand that mathematics should be nothing more than an auxiliary science for fulfilling the purposes of law. This does not imply believing in or being a fervent follower of a particular formula, but merely practicing law. (Acciarri, 2015)

For the purpose of calculating compensation, some authors take the salary the person earned at the time of the crime and project it to the rest of their life; that is, the present value of a constant, non-perpetual income. However, does it make sense to think that a person's income will only be the sole manifestation of their ability? In Argentina, the determination of capital so that their income covers the loss of the victim's ability to carry out productive or economically active activities is not a prerequisite for the compensation.

Valuable makes a distinction between earnings as an employee, as a merchant or entrepreneur.

We must clarify that economically valuable activities include all those tasks that we perform, but if we cannot do them, we have to pay someone, such as: self-transportation, self-hygiene, among others.

In the case of disability, if we can't perform them, we have to pay a third party to do them for us, and it wouldn't be the same as, for example, comparing it to the act of dancing. The action that produces that act, that is, the enjoyment of dancing, falls within the dimension of non-patrimonial damage. Another example would be practicing a sport for mere enjoyment. It wouldn't make sense for me to hire someone and watch them play ball for the mere enjoyment of it. But it does make sense for someone to hire someone else to transport them when they can't do it themselves.

So, if we start from this distinction between assets and non-assets, assets include many things besides income, but not everything. Naturally, life has many dimensions, but the point is that some dimensions fall within the sphere of assets and others don't. Within assets, we have productive or economically valuable activities.

In Argentina, there are formulas for calculating compensation. Both the Vuotto and Méndez formulas are two systems used to calculate compensation for work-related accidents. These formulas derive from court rulings, hence their names, where greater justice was applied to the reparation of damages. (Acciarri, 2015)

The problem with the first of them, the Vuotto formula, is that people believed that when applying it, the income variable was filled with the salary.

to where the capacity ended by multiplying it by 0.65 and completing the discount rate with 6, thinking that completing the variables of a formula was part of its application or that the way of filling in the variables was intrinsically linked to the application of the formula, and this would not have to be the case.

Applying a formula is one thing, and filling in its variables is another. If we distinguish these two problems, we realize that Vuotto's formula could be improved. However, there are objections from Arostegui that the formula cannot overcome. (Acciarri, 2015)

One of the problems raised is the salary the victim earned at the time of the events projected over the rest of his working life. This is a problem the Vuotto formula cannot directly overcome because it is designed to determine the present value of a constant income, and what we are considering is a variable income. Therefore, would it make sense to think that a 20-year-old would have a higher explicit market income at 40 than he had at 20? It would seem so; this is within the well-known facts; however, the formula proposed by Vuotto cannot calculate it.

Later, Méndez's formula appeared, which attempted to remedy Vuotto's problems by extending the age of 65 to 75 years of working life to estimate the calculation, changing the discount rate from 6 to 4, resulting in a tremendous compensation, because the lower the discount rate, the higher the present value. The most interesting aspect of Méndez's work is that he elaborates the following: the current income (at the time of the event) is multiplied by 60 and then divided by the victim's age, considering a maximum of 60. That is, if the victim is 20, it is divided by 20, and if the victim is 61, it is divided by 60.

Would it make sense or would it be absurd to think that at age 60 I have an income three times what I earned at age 20? It's not absurd; a ruling that mentions those terms wouldn't be arbitrary. For calculating compensation, Vuotto's formula provides less compensation than when we apply Méndez's formula. (Acciarri, 2015)

If economic analysis of law teaches us anything, it's to make things more complex in a modular way. That is, Méndez's formula overestimates because it calculates the maximum but then uses Vuotto's formula, which diminishes it.

And now another problem arises: Is there a single income curve for all human beings? The question is intuitive; the idea is that there is an additional benefit for seniority, that is, a real, additional increase per year. Thus, we would have many arguments in favor of Méndez's formula, and others in favor of Vuotto's. Most calculations produce curves that peak at the peak of productive age and subsequently flatten out as age progresses.

On the other hand, let's think of each year as a discrete period, that is, we know that a variable is discrete when it is or is not, for example, if something is present or absent, it would be a discrete variable. Let's think of each year as a discrete variable, to get the present value of a year.
What would we do? We simply divide the income from a year's rent by 1 plus the interest rate, that is, A1/(1+i). For example, applying the formula, if I have 100 and divide it by 1.04 (an annual interest rate of 4%), it would give 96.15, which guarantees that, given an annual interest rate of 4%, it would result in a total of 100. That is:

$TO_{1/}$ (1+i)= 100/(1+0.04)= 96.15 then 96.15x1.04=100

Where A_1 is the value of one year's income and where i is the interest rate. The present value and an amount that is charged at interest gives us the future value.

They are two sides of the same coin, just as something divided by two is the opposite side of twice the size of each of those halves; this is a rigid mathematical relationship; it's not a matter of debate. (Acciarii, 2015)

If I subtract a rate from something and then add it together, I get that amount. So it's an equality, an equation. The word equation means equal in Latin, aequatio, where the present value of 100 in one year, if I discount an interest rate of 0.4%, is 96.15 in that year.

So if we can calculate the value of one year, what happens with the second year? I could do the same with the small difference that if I give a person two years, during the first they consume and the other they reinvest, then what would have to be done is simply use a compound interest formula, since by having the calculation of the first two years the problem would have been solved, the years that follow are equal, the third I divide it by 1 + i cubed, the fourth 1 + i to the fourth, the fifth 1 + i to the fifth.

Now, there are those who believe that increased income should be considered "chances," while the income the victim was receiving should be considered "certain damages." And here there is an important difference, because how do we value a chance for compensatory purposes?

The Mazeaud brothers' example is as follows: We have a horse that is going to compete in a race for a prize of one million pesos and dies before the race. Now, how do we compensate for the chance of having won the prize? What probability would the horse have of winning it? Or against how many horses was our horse competing? This last piece of information would be relevant if we have no other information, but the horse - even if it has to compete against ten stallions - may not have a tenth, but a 1 or perhaps a 50. The other ten horses would help us know how much it would have; once we know that probability, either because we estimate it or presume it,

Let's suppose it's 1/10, one tenth multiplied by a million, then we have that one tenth of a million is 100,000, so I'm not going to compensate my horse's chance with one million, but with 100,000.

Now, what did we do? We multiplied that increased income, the sum or the million by the probability, but unlike the previous example, the discrepancy we have with the income of a person and with the horse, is that the horse has two options: win or lose, that is, the result of the race can be zero or a million, while in the increase of the person the options are to increase or not increase, but if it is not increased the result would not be zero; such that if someone is earning an amount of 100 and we think that they can increase their earnings to 150, this would result in them winning 150 or 100.

So we multiply the probability of the new sum by 1-p, which is the complementary probability of the other sum. That is, if the victim has a 70% chance of earning a higher income and a 30% chance of earning the same income, or if the victim has only a 10% chance of earning more and a 90% chance of continuing to earn the same amount, we must reasonably and professionally employ a mechanism to provide the victim with fairer compensation options.

The formulas designed by Vuotto and Méndez have disadvantages, however, Would the problem be the formula or the calculation tool? Perhaps it's comparable to when we need to calculate variable-rate interest. In fact, in other countries, software already exists that can perform these compensatory calculations, but the underlying idea is to do so in the most fair and equitable way possible. (Acciarri, 2015)

Regarding technological systems for calculating moral damages, andIn the legal field, these play a crucial role in simplifying and streamlining various tasks, including the calculation of compensation for

damages to victims by allowing legal professionals to collect, organize, and analyze relevant data more efficiently, which can result in a more accurate assessment of compensation.

One of the most widely used software names in the legal field is "Eclipse Legal Systems." It offers functionalities for managing legal cases, including compensation calculations. You can input information about the damages suffered by the victim, such as medical expenses, loss of income, and emotional damages. It automatically generates an estimate of the appropriate compensation, while streamlining the process for attorneys and ensuring that all relevant factors are taken into account when calculating compensation.

Regarding the benefits for calculating compensation, the most notable are its speed and accuracy, allowing complex calculations to be performed in a matter of seconds, saving lawyers time and effort. Furthermore, by using structured data and specific algorithms, human error is minimized and a more accurate estimate of the appropriate compensation is obtained. (Acciarri, 2015)

It is important to consider the potential harms of using these systems. Although they are useful tools, they should not replace the judgment and experience of attorneys. The results generated by the software must be reviewed and validated by legal professionals to ensure they are appropriate and fair to the victim, as many technological systems lack the ability to perform subjective analysis, which can limit their effectiveness in moral damages cases. Furthermore, some software may have associated costs that must be considered before implementation.

Reparation for moral damages to a crime victim is a complex and varied issue across different legal systems around the world. However, some common systems and parameters used to calculate moral damages are as follows:

1. Fixed compensation system: Some countries establish a fixed amount or a predefined scale for moral compensation, without taking into account the individual circumstances of the case. This may simplify the process, but it can also be unfair to the victim if the real impact of the harm suffered is not taken into account.
2. Pain and suffering-based system: This system seeks to calculate moral compensation based on the physical or emotional pain experienced by the victim. In some cases, mathematical formulas are used that consider factors such as the severity of the injury, the duration of the suffering, and the impact on quality of life.
3. Income- or economic capacity-based system: Some countries consider the victim's income as the basis for determining non-pecuniary compensation. This may involve calculating an amount proportional to lost income or harm caused to the victim's ability to work or earn income, loss of earnings, and consequential damages.
4. Precedent-Based System: In many legal systems, moral damages are established based on previous court decisions in similar cases. The circumstances and impact of the harm suffered by the victim are analyzed to determine a fair and proportionate amount.
5. Objective valuation system: Some nations use a more objective approach to calculating non-pecuniary damages, taking into account factors such as the severity of the crime, the psychological and emotional impact on the victim, the duration of suffering, and other quantifiable elements.

It is important to note that these systems and parameters may vary by country and legal context. Furthermore, fairness in moral compensation is not only based on a specific formula or system, but also on considering the individual circumstances of each case and the actual impact suffered by the victim. (Acciarri, 2015)

To achieve adequate compensation and avoid leaving the victim disabled, some important parameters to consider are:

1. Individualized assessment: Each case must be assessed individually, considering the specific circumstances and the emotional and psychological impact suffered by the victim.
2. Victim Participation: It is essential that the victim be allowed to express their experience and the consequences of the harm suffered, so that their voice is heard and considered when determining moral compensation.
3. Consideration of subjective factors: In addition to objective aspects such as physical pain or economic loss, subjective aspects such as emotional suffering, psychological trauma, and the impact on the victim's quality of life must be taken into account.
4. Proportional compensation: Moral compensation must be proportional to the harm suffered by the victim, ensuring that the negative impact on their life is adequately recognized and compensated.

Regarding compensation for moral damages in some countries of the world:

In the United States, the moral damages compensation system is based on an assessment of the injuries and the consequences for the victim. This results in a monetary sum calculated based on how the victim's life has been affected. For example, factors such as the severity of the injury, recovery time, loss of skills or employment, and pain and suffering suffered as a result of the incident are taken into account. (Acciarri, 2015)

In Brazil, compensation for moral damages is one of the highest in the world, as it is based on the proportionality of the offense. This means that the severity of the act and the impact it has had on the victim's life and those around them are considered. When calculating compensation, factors such as pain, shame, humiliation, loss of dignity, and the suffering of the victim and those close to them are taken into account.

Compensation for non-material damages is calculated in Spain based on an assessment of the consequences of the injury suffered by the victim. This is done through a table of legal scales that establish the economic value based on the severity of the injury and the likelihood of full recovery.

Compensation for moral damages in Mexico is based on the need to compensate the victim for the pain and emotional suffering. The amount is calculated based on various factors such as the severity of the injury, the victim's age, the level of disruption to their work or personal life, and the psychological impact the incident has had on their loved ones.

The fairest and most appropriate way to calculate compensation for non-material damages is through mathematical formulas because they are generally more accurate and objective. For example, in Australia, a mathematical formula is used to calculate compensation for pain and suffering that takes into account factors such as the severity of the injury, recovery time, and the victim's age.

Conversely, some argue that one way to calculate compensation for moral damages is to award a fixed amount to all victims, regardless of the severity of the case. This view is based on the idea that equality should prevail over all other factors. However, this method of calculation has been criticized for failing to take into account the individual nature of each case. (Acciarri, 2015)

Case No. 4.Exp. AA20-C-2022-000432. Civil Cassation Chamber. Judge Speaker: José Luis Gutierréz Parra. Parties: Maytte Cecilia Fagundez Blanco vs. Betty Milagros Parraga and Jesús O. Pereira M. and Clínica El Ávila CA

We evaluate this sentence linked to the area of plastic surgery, where a patient undergoes a plastic surgery correction for encapsulation of a breast prosthesis at the El Ávila Clinic, where the surgeon used a technique never used by her before, and subsequently

The condition evolved unsatisfactorily, requiring necrectomy, debridement of the breast tissue, use of intravenous antibiotics due to the growth of a Pseudomonas aeruginosa bacteria, due to secretion in the tissue of the operated breast, in addition to hyperbaric oxygen and finally a new reconstructive intervention of the breast with a new surgical intervention to perform a graft taken from the patient's labia minora.

All of this resulted in financial, moral, and emotional expenses, including couples' counseling, for the plaintiff. The physicians, the attending surgeon, and the substitute physician who assisted in the patient's follow-up care were sued.

The healthcare institution was exonerated from the alleged lack of relationship between the clinic, the doctors, and the unlawful act. This fact arose from the doctors' own statements, which the defendant alleged, under Articles 1,185 and 1,196 of the Civil Code. In the present case, it arose from damages arising from a contractual relationship in which the parties have neither the status of agent nor victim, and the parties are bound by a contract.

In applying Article 1190 of the Civil Code, the joint relationship between the damage or wrongful act and the clinic was not demonstrated because neither the plaintiff nor the defendants established what type of relationship or connection they had with the clinic, that is, whether they were dependents or employees of the clinic.

It was also not proven that the hospital-acquired bacterium Pseudomonas aeruginosa was acquired by the patient according to the CICPC report, and consequently, the appellate judge would have incurred in false application of art.

1,191 and 1,196 CC by declaring the claim admissible and condemning the El Ávila Clinic to jointly pay moral compensation, consequently the ad quem judge should have declared the claim against the doctors admissible and the clinic's lack of passive quality since it was not demonstrated that the clinic had any responsibility in the unlawful act caused to the patient-plaintiff in the

controversy and so it is decided. The petitum doloris was made at the judge's discretion.

Now, in this case, several factors must be taken into account that could have influenced a different decision, among which we mention the following:

1.-) The tacit obligation of guarantee and security that must exist in every healthcare institution where a patient attends, that both its facilities and all its staff will safeguard the health of those who visit them, and this is present in the Law on the Practice of Medicine and other codes. Furthermore, the surgeons did not perform medical activity in an apartment or a hotel, but in an institution that has all the necessary permits and that has the tacit extracontractual liability not to cause harm, a liability of guarantee, security, and surveillance as a bonus pater familiae of all those who carry out activities within its facilities. It is important to highlight that the surgeon operates, performs a surgical procedure within the clinic facilities, is a shareholder of that institution and, derived from that surgical procedure, always provides a share of profit to said institution, that is, the charges to the patient for: expenses for supplies: surgical gowns, gloves, masks, boots, disinfection material, solutions for intravenous use, use of antibiotic medications, expenses for the anesthesiologist, use of the surgical area, nurses, among others, which are deducted from the fees of the plastic surgeon shareholder. That is, they certainly benefit from the doctor's performance for the use of their facilities.

2.-) The lack of an adequate independent forensic medical expertise, where the expertise of a microbiologist, or infectious disease specialist or epidemiologist would have been requested, to request the culture of the areas of the health facility, in order to determine if the so-called Pseudomonas aeruginosa bacteria was present.

present in antiseptic solutions, operating room, povidine, floors, walls, sutures, nebulization devices or others.

Had a link been established between the discovery of the bacteria and its presence in a particular area, the decision would have made the clinic co-responsible for the patient's slow progression. This is a section we explore in our research, in the chapter concerning medical errors in the case of nosocomial infections, that is, infections occurring in healthcare facilities. Furthermore, postoperative infections can increase the risk of deformed or disfiguring scars during the healing process.

3.-) Analysis of the surgical technique used by the surgeon and the situation in the operating room: The double-stitch technique is a plastic surgery technique in which two stitches are used to close the wound, allowing for greater tension and preventing scarring. However, any type of surgical intervention carries an inherent risk of complications such as infection, excessive bleeding, or allergic reactions to anesthesia.

In the present case, the patient suffered an asthma attack during surgery, which may have contributed to the poor outcome. The asthma attack could have been triggered by an allergic reaction to the anesthesia or by the position in which the patient was positioned during the procedure, which made breathing difficult. In any case, the surgery should have been suspended immediately to treat the asthma attack, if it was severe (not documented in the judgment) and to ensure the patient's safety.

However, we do not know whether the plastic surgeon took these measures or whether the private clinic where the surgery was performed actually had the appropriate means at that time to deal with the patient's asthma attack. Whether the plastic surgeon did not cancel the procedure or whether the clinic did not

possessed the means to efficiently treat the asthma attack, both could be considered responsible for the poor evolution of the condition and the infection by the Pseudomona aeruginosa bacteria.

During a surgical procedure, the presence of an asthma attack or bronchial hyperreactivity would represent a challenge for the medical team, as it would affect the progress of the surgery.

When an asthma attack occurs during surgery, the best strategy will depend on the severity of the attack and the type of surgery being performed (for example, whether it is an emergency surgery such as an appendectomy or an elective surgery such as an inguinal hernia repair).

If the attack is severe and life-threatening, discontinuing surgery may be the best option, while if the attack is mild or moderate, the option may be to continue the surgery as long as the anesthesiologist and medical team are prepared to handle any resulting complications.

However, the decision to discontinue or not discontinue surgery in cases of asthma attacks should be made with caution, as both discontinuing and continuing surgery can have negative consequences. If the decision is made to discontinue surgery, there is a risk of complications related to the condition that prompted the surgery in the first place, for example, failure to resolve a perforated appendicitis, which would delay necessary treatment and prolong the patient's recovery.

Conversely, continuing surgery during an asthma attack can increase the risk of intra- and postoperative respiratory complications, which would prolong the hospital stay and delay recovery. Furthermore, it would increase stress on the patient's body, worsening the asthma attack and increasing the risk of complications.

Thus, the decision to suspend or continue surgery in the event of an asthma attack should be made by the medical team supervising the case and should be based on the severity of the attack, the type of surgery being performed, and the patient's overall condition.

It is worth mentioning that, although the judgment did not find the private clinic jointly liable because there was no contract between it and the plaintiff, nor was the relationship between the clinic, the doctors, and the wrongful act proven, it is therefore necessary to emphasize that Anglo-Saxon common law doctrine gives rise to the doctrine of apparent representation. This doctrine is understood as a set of legal relationships that may or may not have a contractual origin and that allow a person called a representative to generate legal ties with third parties on behalf of the represented party. To achieve these effects, Anglo-Saxon law also recognizes as a representative any person who works under the supervision of a superior and who deals with a third party on that person's behalf, the most typical example of this relationship being that of employer and employee.

Apparent representation is the legal concept created by Anglo-Saxon law that allows legal ties created from deficient or even non-existent representation, but apparently legitimate, to be considered effective. Its purpose is to protect the interests of third parties so that they are able to enforce them with respect to the legal relationships established with the person believed to be validly represented. (Grayeb, 2019, 5)

There are three conditions to be aware of when assessing whether you are dealing with a case of apparent representation, which are:

1. A subject who holds representation when performing acts on behalf of a third party.

2. A subject who is supposedly being represented and who, through his positive or negative actions, does not destroy the false idea that such representation exists.

3. The reasonable belief held by a third party in good faith that such representation exists.

One of the precedents of the use of the figure of apparent representation to resolve a controversy related to the provision of medical services is found in the case Gilbert vs. Sycamore Municipal Hospital, in which the hospital was brought to trial for allegedly negligent acts attributable to the professionals who provided medical care in the institution's facilities despite the fact that they were not part of its list of employees or representatives and who were presented in court as if they were only providers of services on a sporadic and specific basis. (Grayeb, 2019, 7)

In this sense, it could be understood that the institution sought to avoid being held liable for the conduct of physicians with whom it does not have a supra-subordinate relationship; however, the Court of Appeal noted that the existence of an employment or representation relationship is not the only way to create liability for the institution in question, but that its duties extend to the obligation to effectively supervise the performance of said physicians in their interactions with patients.

Another important precedent for the development of this criterion was the 1980 case of Lynch vs. Board of Education of Collinsville Community Unit District. This ruling determined that the person apparently represented must create a reasonable image of the existence of the representation through his or her words or conduct in order to be considered legally responsible. For the specific case of the appearance of legal representation in the provision of services,

For physicians, the American courts find two ways of understanding the responsibility of medical service providers applicable:18 a) The hospital's responsibility arises from the conduct of those who are subordinate to them as employees. b) Hospitals are responsible for their special duty to monitor the quality of care and services their patients receive.

In Mexico, according to Grayeb, the thesis put forward is the following: "it maintains that appearance is capable of producing the same effect as reality, that is, giving legal effects to that which is not real but apparent" and that its application is not limited to those cases expressly indicated by law, so that it is possible to extend its use to analogous cases, especially in those in which there is a need to protect the legal interests of third parties who have acted in good faith, especially if they are in a vulnerable position with respect to those who have generated and sustained the appearance. (Grayeb, 2019, 7)

The Supreme Court extends the application of this criterion even to cases in which the patient has been informed that the medical personnel are not part of the institution's workforce. The Mexican Supreme Court argues that validating this statement as a reason for excluding the institution from liability would create a certain immunity in cases where a claim for benefits arising from medical malpractice is admissible.

This would directly affect the proper exercise and enjoyment of the human right to health by exacerbating the vulnerable situation faced by users of these health services. This unequal relationship has been recognized by the Mexican court, which has established that patients suffer from this inequality.

The adoption of this regulation reaffirms hospitals' obligations to continuously monitor the quality of services they provide to their patients, including the obligation to have dedicated staff to supervise who interacts with patients and to monitor the treatments their employees assign to each patient.

Proper integration and application of apparent representation aims to prevent the simulation of professional service contracts between physicians and patients, the economic benefits of which are shared between the hospital and the physician, but in which the physician is the sole party responsible for the medical act. Therefore, it is a doubly protective measure, as it would prevent the treating physician from being responsible in all cases for repairing or compensating for damages caused by malpractice. It is worth remembering that in private healthcare institutions, when providing medical-surgical services, fees are charged for the use of the facilities during the surgical procedure, that is, for the use of nurses, anesthesiologist, as well as the provision of medical supplies for the proper performance of the surgical intervention: gloves, solutions, anesthetic medications, gowns, caps, face masks, and other supplies. (Grayeb, 2019, 7)

The problem with applying this doctrine or its rulings in Venezuela is that, since it involves a human right such as the right to health and the right to life, it would have to go through the Constitutional Court, which would determine its applicability.

10.2.- Foreign judgment for medical malpractice. Inter-American Court of Human Rights

Case of Albán Cornejo et al. v. Ecuador. Judgment of November 22, 2007. (Merits, reparations, and costs)

Victims: Carmen Cornejo de Albán and Bismarck Albán Sánchez.

Representatives: Legal Clinics of the College of Jurisprudence of the San Francisco University of Quito, Ecuador.

Respondent State: Ecuador.

Summary: The case concerns the international responsibility of the Ecuadorian State for its failure to investigate and punish those responsible for the death of Laura Susana Albán Cornejo in a private hospital.

Violated rights contained in the American Convention:

Obligation to respect rights, Article 1; Freedom of thought and expression, Article 13; Protection of the family, Article 17; Duty to adopt domestic legislation, Article 2; Judicial protection, Article 25; Right to life, Article 4; Right to personal integrity, Article 5; Judicial guarantees, Article 8.

Summary of the facts: On December 13, 1989, Ms. Laura Susana Albán Cornejo was admitted to the Metropolitan Hospital of Quito, Ecuador, presenting with bacterial meningitis. On the night of December 17, she developed a severe headache and was prescribed 10 mg of morphine by the resident physician. On December 18 of that same year, she died, allegedly due to the medication administered. The two physicians who were treating her were reported by her parents for medical negligence. One of the doctors investigated was acquitted, while the other was pending a judicial resolution.

Proceedings before the Inter-American Court of Human Rights (IACHR):

The case was referred to the IACHR on July 5, 2006.

Petition from the IACHR to decide whether the State violated the rights enshrined in Articles 8 and 25 of the American Convention in connection with Article 1.1 thereof, to the detriment of the victim's parents.

Petition by Carmen Cornejo de Albán and Bismarck Albán Sánchez (parents), requesting that the IACHR declare that the Ecuadorian State violated the rights enshrined in Articles 4, 5, 8 and 25 of the American Convention, in

To the detriment of Laura Albán and Articles 5, 8, 13, 17 and 25 of the American Convention, to the detriment of Carmen C. de Albán and Bismarck Albán S, the representatives alleged violation of these articles together with Articles 1.1 and 2 of the American Convention.

At the IACHR hearing on May 16, 2007, the Court accepted the partial recognition of the Ecuadorian State's international responsibility. The Court notes in its explanatory section that: Regarding the right to life (Art. 4.1), the Court did not find sufficient elements to attribute international responsibility to the State for the death of Laura Albán, under the terms of Article 4 of the Convention. Without prejudice to the foregoing, the Court examined whether the State has fulfilled its obligation to guarantee the right to life by conducting a thorough investigation to clarify the facts of the present case, which refers to a complaint that constituted a crime.

Background analysis:

Regarding the Right to personal integrity (Article 5.1): In the present case, the close emotional bond between the parents and their deceased daughter is proven, sufficient to consider them victims of acts that violate Article 5 of the American Convention, and in particular, the situation of Carmen.

C. de Albán, who dedicated herself to the pursuit of justice regarding the circumstances surrounding her daughter's death. Therefore, the Court found that the lack of a judicial response to clarify Laura Albán's death harmed the well-being of her parents, making the State responsible for violating the right enshrined in Article 5.1 of the Convention, in conjunction with Article 1.1 thereof, to the detriment of the aforementioned persons.

Freedom of thought and expression, art. 13: The Court observed that the right to know the medical record is subsumed within the right of the victim or his or her family to obtain from the State the clarification of the violated facts and the definition of the corresponding responsibilities, therefore, the

The Court records the alleged violations of Articles 8 and 25 of the Convention.

Protection of the family Art. 17: The invocation of this article was dismissed by the Court because it was considered and decided in accordance with Art. 5 of the American Convention on Human Rights.

Judicial Guarantees. Articles 8.1 and 25.1 in relation to Article 1.1 of the American Convention: The Court recognized in previous cases that the State is internationally responsible for acts or omissions of any of its powers or organs that violate internationally recognized rights, according to Article 1.1 of the Convention, and Articles 8 and 25 specify the acts or omissions of domestic judicial organs. Thus, States have a general obligation to guarantee the free and full exercise of the rights recognized by the Convention to all persons within their jurisdiction. One of the positive measures that States Parties must take to safeguard the obligation of guarantees is to provide effective judicial remedies in accordance with the rules of due process, the restoration of the violated right, and, where possible, reparation for the damages caused.

The duty to investigate must be fulfilled seriously and not as a mere formality doomed in advance to be fruitless. It must be assumed by States as their own legal obligation and not merely as a means of managing private interests, dependent on the judicial initiative of the victim or their family, or on the private provision of evidence, without the public authority effectively seeking the truth. Due diligence requires that the investigating body carry out the necessary actions and inquiries to achieve the desired result. Otherwise, the investigation is not effective under the terms of the Convention.

Procedures completed before the criminal proceedings. Medical record:

The Court understands that medical records contain personal information, the handling of which is generally confidential. The custody of medical records is regulated by the internal regulations of each State, which generally entrust it to the attending physician or to the public or private health centers where the patient is treated. This does not prevent, in the event of death and even in other situations, in accordance with the respective regulations, the records from being transferred to immediate family members or responsible third parties who demonstrate a legitimate interest.

In general terms, the importance of a properly compiled medical record is evident as a guiding instrument for medical treatment and a reasonable source of knowledge about the patient's condition, the measures adopted to manage it, and, where applicable, the resulting responsibilities. The absence of a record or its poor integration, as well as the absence of regulations governing this matter under ethical standards and rules of good practice, constitute omissions that must be analyzed and assessed, taking into account their consequences, to establish the possible existence of responsibilities of various kinds.

The powers exercised by the Court of Honor (College of Physicians and Medical Federation in Venezuela) in accordance with the powers assigned by domestic legislation are not conditions or substitutes for decisions that may be adopted by an administrative or judicial body of the State, nor do they relieve the latter of any liability it may incur.

The Court emphasized the importance of the work carried out by this body in investigating and eventually imposing disciplinary sanctions on the professional conduct of physicians, among other things, when negligence in professional practice is alleged.

Among the functions of the courts of professional colleges of medicine are those related to the duty to supervise and ensure the ethical practice of the profession and to protect those legal assets that are related to the

medical practice, such as life, personal integrity and the management of medical-scientific information about patients' health.

For this reason, it is essential that professional oversight bodies, when examining and exercising control over the professional practice of physicians and imposing disciplinary sanctions, do so impartially, objectively, and diligently to protect the assets and values that their professional practice serves, guided by generally accepted principles of ethics, bioethics, science, and technology. It is impossible to ignore the fact that the conclusions reached by professional bodies can significantly influence the examinations conducted by state agencies, even when these bodies are not formally limited, conditioned, or bound by them.

Since the State learned of Laura Albán's death on August 3, 1995, it should have initiated and pursued the investigation and clarification of the facts from that date. However, it was not until fifteen months later that the investigation began, as has been proven. In this regard, this Court considers that the aforementioned incident demonstrates that the State authorities did not take seriously and with due guarantees the complaint filed by Laura Albán's parents. Consequently, the Court finds that the State violated Articles 8(1) and 25(1) of the American Convention by failing to promptly initiate the investigation into Laura Albán's death.

The State itself acknowledged in the present case that the authorities did not diligently pursue an investigation aimed at locating Dr. Espinoza Cuesta and, if necessary, obtaining the defendant's extradition. However, on October 16, 2007, the Fifth Criminal Court declared the statute of limitations on the criminal case against the aforementioned doctor, which was challenged on October 25, 2007, through an appeal.

which was admitted and is currently pending decision before the Superior Court of Justice of Quito.

For all the above reasons, this Court concludes that the State is responsible for the violation of the rights enshrined in Articles 8.1 and 25.1 of the American Convention, in relation to Articles 4, 5.1 and 1.1 of said Convention, to the detriment of Carmen Cornejo de Albán and Bismarck Albán Sánchez.

This Court was recently informed that on October 16, 2007, the Fifth Criminal Court declared the statute of limitations on the criminal case against Dr. Espinoza Cuesta. This decision was appealed and is currently pending resolution by the competent authorities. This decision is not final; that is, it lacks the authority of res judicata. However, the Court has deemed it pertinent to analyze the statute of limitations in light of the facts of the present case, in which the State itself acknowledged its international responsibility for the lack of due diligence by failing to promptly initiate the extradition process for one of the defendants in relation to the investigation into the death of Laura Albán.

The statute of limitations in criminal matters determines the extinction of punitive claims due to the passage of time and generally limits the State's punitive power to prosecute unlawful conduct and punish its perpetrators. This is a guarantee that must be duly observed by the judge for anyone accused of a crime. Notwithstanding the foregoing, the statute of limitations on criminal proceedings is inadmissible and inapplicable when it comes to very serious human rights violations under international law. The Court's consistent and consistent jurisprudence has so indicated.

In the present case, the exclusion of prescription does not apply, because the assumptions of imprescriptibility recognized in international instruments are not met.

Furthermore, the accused is not responsible for ensuring the prompt action of the authorities in the criminal proceedings, nor for the lack of due diligence on the part of state authorities. In a criminal proceeding, the accused cannot be held responsible for delays in the administration of justice, which would result in a violation of his rights under the law.

Provision of health services and international responsibility of the State.

The Court has reiterated that the right to life is a fundamental human right, the full enjoyment of which constitutes a condition for the exercise of all rights. Personal integrity is essential for the enjoyment of human life. In turn, the rights to life and personal integrity are directly and immediately linked to human health care. Furthermore, the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights establishes that everyone has the right to health, understood as the enjoyment of the highest level of physical, mental, and social well-being, and indicates that health is a public good (Article 10).

The Court has held that States Parties to the American Convention have a fundamental duty to respect and guarantee the rights and freedoms established in the Convention, in accordance with Article 1.1. Article 2 establishes the general duty of States Parties to adopt legislative or other measures necessary to give effect to the rights and freedoms recognized in that instrument.

State liability may arise when a State body or official or a public institution improperly affects, through action or omission, some of the legal rights protected by the American Convention. It may also arise from acts carried out by private individuals, as occurs when the State fails to prevent or impede third-party conduct.

that violate the aforementioned legal assets. In this order of considerations, when it comes to essential powers related to the supervision and oversight of the provision of services of public interest, such as health, whether by public or private entities (as is the case of a private hospital), liability arises from the failure to comply with the duty to supervise the provision of the service to protect the respective asset. From the general obligations to respect and guarantee rights derive special duties, which can be determined based on the particular protection needs of the legal subject, whether due to their personal condition or

the specific situation in which you find yourself.

The Court has held that States are responsible for regulating and supervising the provision of health services to achieve effective protection of the rights to life and personal integrity. This requires the development of a regulatory system that effectively respects and guarantees the exercise of these rights, as well as effective and ongoing oversight of the provision of services on which people's lives and integrity depend.

Laura Albán died at the Metropolitan Hospital, a private health center. The State is not immediately responsible for the actions of the staff at this private institution; however, it is responsible for supervising the institution's performance to achieve the purposes referred to in this section.

Legislation related to health and States.

As stated, States must have effective regulations to guarantee that health service users are effectively investigated for conduct that violates their rights. This includes, of course, incidents that arise in the provision of medical services.

The Court recognizes that the State has recently adopted measures aimed at supervising and improving the conditions of the provision of services.

health services, including those aimed at developing national technical standards and protocols related to these services.

The Court welcomes the adoption of measures aimed at supervising and inspecting the provision of health services and advancing the guarantee of the rights to life, personal integrity, and health for people undergoing medical treatment.

Health professionals. Duties of physicians in their professional practice.

Numerous international instruments determine the specific duties of physicians and provide a detailed framework for the practice of this profession, which is subject to highly significant ethical and legal obligations and paramount social expectations. Physicians are concerned with safeguarding the fundamental values of the individual and of humanity as a whole.

Legislation applicable to medical malpractice.

The adaptation of domestic law to the American Convention, pursuant to Article 2 thereof, must be carried out in light of the very nature of the rights and freedoms and the circumstances in which the adaptation takes place, in a manner that ensures their acceptance, respect, and guarantee.

In the present case, the alleged absence or deficiency of regulations on medical malpractice is alleged. States must, of course, adopt the necessary measures, including the issuance of criminal laws and the establishment of a justice system to prevent and punish violations of fundamental rights, such as the right to life and personal integrity.

Medical malpractice is usually considered a criminal offense for bodily injury or homicide. It doesn't seem essential to establish specific types for the former if general definitions are sufficient and there are relevant rules for judicial consideration of the seriousness of the crime, the circumstances in which it was committed, and the culpability of the agent.

In this regard, the Court takes note of the State's decision to review the criminal legislation on medical malpractice and incorporate the necessary clarifications to adapt the legal framework to promote the proper administration of justice in this area.

Repairs:

The Court rules that,

- This Judgment constitutes per se a form of reparation.
- The State must publish the Judgment on the Merits, Reparations, and Costs in the Official Gazette and in another newspaper of wide national circulation within six months.

The State must, within a reasonable timeframe, broadly disseminate patient rights, using appropriate media and taking into account existing Ecuadorian legislation and international standards.

The State must implement, within a reasonable timeframe, a program to train and educate justice officials and health professionals on the regulations that Ecuador has implemented regarding patient rights, and the sanctions for non-compliance.

The State must pay Carmen Cornejo de Albán and Bismarck Albán Sánchez the amount set out in paragraph 153, as compensation for material and immaterial damages, within one year from the notification of the Judgment on the Merits, Reparations and Costs.

The State must pay Carmen Cornejo de Albán the amount set forth in paragraph 168 of this Judgment, for costs and expenses incurred in the domestic sphere and in the international process before the Inter-American system for the protection of human rights, within one year from the notification of the Judgment on Merits, Reparations and Costs.

The Court reserves the right, inherent to its powers and derived from Article 65 of the American Convention, to supervise the full execution of the Judgment on the Merits, Reparations, and Costs. The case will be concluded once the State has fully complied with the provisions of the judgment. Within one year of notification of the Judgment on the Merits, Reparations, and Costs, the State must submit to the Court a report on the measures adopted to comply with it.

Resolution points.The Court declares that:

Accepts the partial recognition of international responsibility made by the State for the violation of the rights to judicial guarantees and judicial protection, enshrined in Articles 8.1 and 25.1 of the American Convention on Human Rights, in relation to Article 1.1 thereof.

The State violated the right to personal integrity enshrined in Article 5.1 of the American Convention on Human Rights, in relation to Article 1.1 thereof, to the detriment of Carmen Cornejo de Albán and Bismarck Albán Sánchez.

The State violated the rights to judicial guarantees and judicial protection enshrined in Articles 8.1 and 25.1 of the American Convention on Human Rights, in relation to Articles 4, 5.1 and 1.1 thereof, to the detriment of Carmen Cornejo de Albán and Bismarck Albán Sánchez.

Comments on this case:

It was the death of Laura Susana Albán Cornejo, who was suffering from bacterial meningitis, in a private hospital in Quito (Ecuador) on 12/18/87. The patient was admitted on 12/13/1987 and her progress was torpid, which led the two treating physicians to give her 10mg of morphine due to a severe headache. She died on 12/18/1987 while receiving treatment.

Parents and other relatives reported the incident to local courts, alleging medical negligence; one of the doctors was acquitted, and another is in the process of being acquitted. Given these results in the local courts, the relatives went to the IACHR on July 5, 2006, requesting a decision on whether the Ecuadorian State had violated Articles 1, 2, 4, 5, 8, 13, 17, and 25 of the American Convention.

On May 16, 2007, the IACHR recognized the Ecuadorian State's partial international responsibility after an exhaustive analysis of the lack of a timely response, the impact on the personal and emotional integrity of the parents, and the violation of the victims' right to medical history, which made it difficult to ascertain the facts and violations and establish the corresponding responsibilities, guarantee due process rules, restore violated rights, and repair damages. The ruling constituted a form of reparation per se, as it was published in a national newspaper, publicizing patients' rights. Training and education programs for justice officials and health professionals on patients' rights and sanctions for noncompliance should be encouraged, in addition to financial compensation totaling US$55,000.00. This case remained under constant surveillance by the family members, preventing noncompliance with the ruling. After 20 years, the IACHR was able to compensate these parents for their suffering and moral damages in their pursuit of justice.

CHAPTER XI

RESULTS TABLES
INTERVIEWS

11.1.-Analysis of results

Using a voluntary and anonymous survey, we investigated the years of service in a group of 150 physicians (100%) working in university hospitals in Caracas, with a range of years of service ranging from less than six to more than thirty years. This group of physicians is barely in the learning process of occupying public positions in health institutions. Of these, 91 (60.66%) had less than 10 years of service in the hospital; 51 (34.03%) had eleven to thirty years of service; and only 8 (5.33%) had worked more than thirty years. It was observed that physicians beginning their postgraduate studies or in the process of completing them corresponded to the largest percentage of the sample studied (61%). (Table 1).

Regarding the question about the perception of the commission of medical malpractice according to the physician's specialty, we evidenced that resident physicians and university postgraduate students had the highest percentage of affirmative responses 56 (37.3%), followed by surgeons, internists, anesthesiologists and gynecologists-obstetricians 52 (34.69%), pediatric intensivists, internists-intensivists, cardiologists and plastic surgeons 28 (18.66%), as well as dermatologists, psychiatrists, traumatologists, neurosurgeons, neurologists 13 (8.65%), only one oncology specialist (0.66%). (Table No. 2)

We investigated the impression that doctors had regarding institutional responsibility and its impact on the occurrence or not of medical malpractice, evidencing hierarchical pressure in decision-making that deviated from medical ethics, such as orders to admit excess patients without availability of clinical beds or prohibition of referring complicated patients to other better equipped hospital centers or with greater resources, if there was no prior dialogue between hierarchical superiors, being forced to discharge patients without clinical criteria for their medical discharge to free up places, receiving despotic, inconsiderate treatment with

threats of dismissal or other sanctions; management positions held by non-medical personnel; working in precarious, unhealthy conditions, without drinking water, electricity, ambulances, surgery, hospitalization, and maternity insurance; lack of air conditioning in critical areas such as operating rooms and intensive care units, and other ergonomic deficiencies in most cases; environmental and personal insecurity; lack of technical and legal advice; receiving salaries that are not commensurate with the increase in the basic food basket; late payments; and lack of salary adjustments based on the professional's specialization. Regarding all of these items included in the voluntary and anonymous survey, 150 (100%) of the physicians answered affirmatively (Table 3).

Regarding the information collected from victims or their families, the type of injuries, damages or sequelae that occurred as a result of medical malpractice was investigated. 11 (55%) mentioned as causes uterine rupture in pregnant women in labor, with a previous diagnosis of pelvic stricture, who were subjected to vaginal labor induction when there was a condition of feto-pelvic disproportion that made it inadvisable; also the forgetting of a foreign body such as gauze, inside the abdominal cavity; also the tip of a scalpel blade inadvertently broken during a complicated neurosurgical procedure; and the perforation of a blood vessel when a cardiological hemodynamic catheterization was being performed; in 6 (30%) a ruptured aneurysm during a neurosurgical procedure; comatose accident post-induction of anesthesia; in 3 (15%) perforation of the jugular vein due to the failed attempt to take a central line; Anaphylactic shock caused by blood transfusion; skin loss due to an allergic reaction to a nonsteroidal anti-inflammatory drug (NSAID). (Table 4)

When victims of medical malpractice or their relatives were surveyed regarding the liability of medical staff, 13 (65%) of the twenty individuals reported that it had consisted of diagnostic error by confusing the type of pathology and adopting incorrect therapeutic practices; other causes were anaphylactic anesthetic shock during the induction procedure or forgetting the medical-surgical material inside the abdominal cavity during the operative act; the remaining 7 (35%) reported treatment errors by confusing one patient with another; the perforation of large vessels during a hemodynamic procedure due to alleged negligence of the medical team with fatal consequences for the patient; and discourteous treatment when they tried to report irregularities to hospital authorities. (Table 5)

The survey explored the responsibility of public health institutions from the perspective of the twenty victims or their families. Thus, 18 (90%) pointed out as a valid contributing factor to medical malpractice the lack of specialized medical and nursing staff in the different hospital services, complemented by the shortage or absence of medical-surgical material, imaging equipment, chemotherapy, radiotherapy and hemotherapy, lack or absence of medications, laboratory, lack of food for patients and formula milk for newborns in detention centers and Neonatal Intensive Care Units (NICU), added to the high health care costs, since the patients themselves must pay for medical-surgical equipment, medications, tubes for taking blood samples, processing of laboratory tests at a dollarized price not always available in the market and whose quality can contribute to the success or failure of an operation; While 2 (10%) blamed the failures of electricity, elevators, drinking water, oxygen, gas, insecurity inside and outside hospitals, and the despotic treatment when they promoted making complaints, claims, or grievances in this regard. (Table 6). In response to the question:

What caused medical malpractice? An analysis of surveys obtained from 20 active professors at the Central University of Venezuela (UCV) revealed that factors attributed to medical acts such as imprudence, acting with inexperience, lack of skill or professional training, or failure to observe existing rules and regulations in health institutions were the cause in the opinion of 10 (50%); other aspects contemplated in the items referring to a lack of specialized medical and nursing professionals, insufficient medications, laboratory, imaging, supplies, air conditioning in operating rooms and intensive care areas, errors committed by staff with more than 24 hours of continuous work, which leads to physical and mental exhaustion known as Burnout Syndrome produced by work overload and lack of rest were the justification in 8 (40%); causes inherent to the patient's failure to strictly comply with the instructions given by the doctor, or fortuitous cases or force majeure in 2 (10%). (Table No. 7).

Is there government liability in the occurrence of medical malpractice? The survey collected the opinions of 20 (100%) UCV professors from which the existence of liability was deduced due to the presence of unhealthy environmental conditions, lack of imaging resources, laboratory, hemotherapy, oxygen therapy, auxiliary power plants, lack of space in intensive care units, food for hospitalized patients, water, bathrooms, formula milk banks, suspension of surgical procedures due to lack of specialized personnel, case of anesthesiologists, essential anesthetic supplies was the response in 9 (45%), receiving hierarchical pressure that sometimes forces the doctor to make decisions contrary to medical ethics, such as discharging patients without clinical criteria to free up spaces, prohibition of referring clinically compromised patients to better equipped public centers, unless the directors of both centers agree, regardless of availability

of the receiving center or the critical conditions of the patient, receiving despotic, inconsiderate and inhuman treatment from higher authorities, working in conditions of environmental insecurity, without HCM insurance, without technical-legal advice (response in 8 (40%)); placing non-medical personnel in management positions, presence of professional demotivation due to low remuneration paid untimely with high work demands, without supplies to provide adequate care was the opinion of 3 (15%). (Table No. 8).

11.2.-Tables

Table No. 1

Medical malpractice. Medical personnel by length of service. Caracas. 2018.

Length of service (years)	No.	%
< 6	56	37.33
7 – 10	35	23.33
11 - 20	28	18.70
21 – 30	23	15.33
>30	8	5.33
Total	150	100.00

Source: Voluntary anonymous survey of 150 physicians from university hospitals in Caracas.

Using a voluntary and anonymous survey, 150 physicians (100%) working at various university hospitals in Caracas were surveyed for years of service. The years of service ranged from less than six to more than thirty. Of these, 91 (60.66%) had less than 10 years of service at the hospital; 51 (34.03%) had eleven to thirty years of service; and only eight (5.33%) had worked for more than thirty years. It was observed that physicians beginning their postgraduate studies or in the process of completing them accounted for the largest percentage of the sample studied (61%). (Table 1).

Table No. 2

Medical malpractice by physician specialty. Caracas. 2018.

Medical specialty	No.	%
Resident physicians in postgraduate training	56	37.33
Surgeons	16	10.66
Internists	14	9.33
Anesthesiologists	12	8.00
Gynecologists and obstetricians	10	6.66
Pediatric intensive care physicians	9	6.00
Intensive care internists	8	5.33
Cardiologists	6	4.00
Plastic and reconstructive surgery	5	3.33
Dermatologists	4	2.66
Psychiatrists	4	2.66
Neurosurgeons / Neurologists	3	2.00
Traumatologists	2	1.33
Medical oncologists	1	0.66
Total	150	100.00

Source: Anonymous and voluntary survey obtained from 150 active physicians from university hospitals in the metropolitan area of Caracas.

The survey showed that resident physicians and university graduate students had the highest response rate, 56 (37.3%), followed by surgeons, internists, anesthesiologists, and obstetricians-gynecologists (52) (34.69%); pediatric intensive care specialists, internists, cardiologists, and plastic surgeons (28) (18.66%); and dermatologists, psychiatrists, traumatologists, neurosurgeons, and neurologists (13) (8.65%), with only one oncology specialist (0.66%). (Table 2.)

Table No. 3

Medical malpractice. Institutional liability according to doctors from university hospitals in Caracas. Caracas, 2018.

Institutional responsibility	Yeah	No	n	%
Higher hierarchical pressure in decisions Higher orders in patient admission	+	-	150	100.00
no beds available	+	-	150	100.00
Prohibition of referring patients to other centers	+	-	150	100.00
Forcing discharge of patients without discharge criteria to release new quotas	+	-	150	100.00
Working in unhealthy conditions and ergonomic poverty	+	-	150	100.00
Authoritarianism, despotism and the threat of dismissal by the hierarchical superior	+	-	150	100.00
Lack of environmental safety and advice technical-legal	+	-	150	100.00
Precarious salaries, no HCM, late payments	+	-	150	100.00
Management positions held by non-medical personnel			150	100.00
Total	+	-	150	100.00

Source: Voluntary anonymous survey of 150 practicing physicians at university hospitals in Caracas. All responses were affirmative. Caracas 2018.

Physicians' perceptions of the State's responsibility or inaction and its impact on the occurrence of medical malpractice were investigated. Questions were asked about issues such as receiving hierarchical pressure to make decisions contrary to medical ethics, such as orders to admit overflowing patients without available beds; prohibition on referring complicated patients to better-equipped or more well-resourced hospitals; being forced to discharge patients without clinical criteria for discharge in order to obtain available spaces and maintain the appearance of efficiency; receiving despotic and inconsiderate treatment, with threats of dismissal or other administrative sanctions from superiors or immediate authorities; positions held by unqualified personnel; working in precarious and unsanitary conditions, without drinking water, electricity, transportation, surgery, hospitalization, and maternity insurance; without air conditioning in critical areas and other ergonomic deficiencies in most cases; environmental and personal insecurity, without technical-legal advice; Receiving salaries that are not commensurate with the increase in the basic food basket or the professional's specialization; and delayed payments. Regarding all of these survey items, 150 (100%) of the physicians answered affirmatively. (Table 3)

Table No. 4

Medical malpractice. Damages according to victims or their families. Caracas 2018.

Damage according to victims	No.	%
Oblite in cavity	4	20.00
Uterine rupture in a patient in labor	4	20.00
Vessel perforation during procedure hemodynamic	3	15.00
Aneurysm rupture during catheterization	3	15.00
Post-anesthesia comatose accident	3	15.00
Jugular perforation during venous access central	1	5.00
Anaphylactic shock during transfusion	1	5.00
Skin loss due to painkiller allergy	1	5.00
Total	20	100.00

Source: Anonymous voluntary survey of 20 victims or their families at university hospitals in Caracas. All responses were affirmative. Caracas 2018.

In the survey designed to gather information from victims or their families, information was requested on injuries, damages, or sequelae caused by malpractice. 11 (55%) noted the following causes: uterine rupture in a patient in labor with a previously diagnosed pelvic stricture; leaving a foreign body such as gauze, compresses, clamps inside the abdominal cavity, or the tip of a scalpel blade behind during a neurosurgical procedure; and vessel perforation during a cardiac catheterization procedure; in 6 (30%), a ruptured aneurysm during a neurosurgical procedure; comatose accident post-anesthetic induction; and in 3 (15%) jugular vein perforation during central line withdrawal, anaphylactic shock during a blood transfusion, or skin shedding due to an allergic reaction to a nonsteroidal anti-inflammatory drug (NSAID). (Table 4)

Table No. 5

Medical malpractice. Liability of medical personnel according to victims. Caracas. 2018.

Responsibility of medical personnel	Victims	
	n	%
Diagnostic error	6	30.00
Anesthetic shock	4	20.00
Forgotten medical/surgical supplies	3	15.00
Rude/inhuman treatment in response to complaints	3	15.00
Treatment error	2	10.00
Large vessel perforation	2	10.00
Total	20	100.00

Source: Voluntary and anonymous survey of 20 victims or their families at university hospitals in Caracas. All responses were affirmative. Caracas 2018.

When victims of medical malpractice or their relatives were surveyed regarding the liability of medical staff, 13 (65%) of the twenty individuals reported that the liability had included misdiagnosis due to confusing pathologies and inappropriate therapeutic practices, anesthetic shock during anesthesia induction due to anaphylaxis, and the forgetting of medical-surgical material (oblito) inside the abdominal cavity during the operation; 7 (35%) reported discourteous and inhuman treatment when they attempted to report irregularities to hospital authorities, the mistaken application of treatment to one patient after another, or the perforation of large vessels during a hemodynamic procedure due to apparent negligence on the part of the medical team. (Table 5)

Table No. 6

Malpractice. Liability of public hospitals according to victims or their families. Caracas. 2018.

Responsibility of public institutions	n	%
Insufficient specialized medical personnel	2	10.00
Insufficient specialized nursing staff	2	10.00
Scarce medical-surgical material	2	10.00
Lack of laboratories and radiology	2	10.00
Absence of chemo and radiotherapy	2	10.00
Medications that are expired, insufficient or missing	2	10.00
Lack of food for patients	2	10.00
Absence of infant formula for newborns	2	10.00
Despotism of directive authorities before complaints, requests or reports	2	10.00
Power, water, air failures.	2	10.00
Total	20	100.00

Source: Voluntary and anonymous survey of 20 victims (patients) or their relatives in university hospitals of Caracas. All the answers were affirmative. Caracas 2018.

The survey explored the responsibility of state institutions from the perspective of the victims or their families. Eighteen (90%) indicated the lack of specialized medical and nursing staff in hospital services, as well as the shortage or absence of medical-surgical material and imaging, chemotherapy, radiotherapy and hemotherapy equipment, lack or absence of medications, laboratory, lack of food for adult patients and formula milk for newborns in Neonatal Intensive Care Units (NICU), high health costs, since patients must buy medical-surgical equipment; while two (10%) reported power failures, stoppage of elevators, lack of drinking water, gas, insecurity due to an increase in crime involving theft and armed robbery inside and outside hospitals, despotic treatment by the management authorities when they promoted the filing of reports, claims or complaints in this regard. (Table No. 6)

Table No. 7

Medical malpractice. Causal liability according to lawyers from the Central University of Venezuela. Caracas. 2018.

What caused it?	n	%
Imprudence	4	20.00
Inexperience	3	15.00
Failure to comply with rules and regulations	3	15.00
Lack of medication, laboratory, imaging and supplies	3	15.00
Insufficient specialized doctors and nurses	3	15.00
Physical/mental exhaustion due to work overload	2	10.00
Inherent to the patient (disregard for treatment)	1	5.00
Act of God / force majeure	1	5.00
Total	20	100.00

Source: Voluntary and anonymous survey of 20 professors at the Faculty of Law and Political Sciences (FCJP). Central University of Venezuela. All responses were affirmative. (UCV). Caracas 2018.

What caused medical malpractice? From the analysis of surveys obtained from 20 active professors of the FCJP of the UCV, it is deduced that the imprudence, inexperience and non-observance of norms and regulations existing in the institution was causal in (50%); lack of specialized doctors and nurses, as well as insufficient medications, laboratories, imaging, supplies, air conditioning in operating rooms and intensive care areas, errors committed by personnel with more than 24 hours of continuous work, which leads to physical / mental exhaustion (Snd. of Burnout) due to work overload and lack of rest 8 (40%); as well as the causes inherent to the patient's failure to strictly follow the instructions given by the doctor, or fortuitous cases or force majeure, as occurred in the operating room of the University Hospital of Caracas when the surgeons were operating on a gunshot wound victim and a situation of assault and kidnapping of the wounded man by a criminal gang occurred, 2 (10%). (Table No. 7)

Table No. 8

Medical malpractice. Institutional liability according to lawyers from the Central University of Venezuela. Caracas. 2018.

Institutional responsibility	n	%
Unhealthiness and ergonomic poverty	3	15.00
Lack of medicines and food for patients	3	15.00
Failure of priority diagnostic resources	2	10.00
Hierarchical pressure to engage in unethical behavior	2	10.00
Forcing the doctor to discharge patients without clinical criteria	2	10.00
Prohibition of referring patients to better-equipped institutions	2	10.00
Despotic treatment of superior authorities towards subordinates	2	10.00
Lack of environmental safety, HCM, and legal advice	1	5.00
Suspension of surgical procedures for lack of personnel or supplies	1	5.00
Management positions awarded for political reasons	1	5.00
Precarious salaries not adjusted to professionalization	1	5.00
Total	20	100.00

Source: Voluntary and anonymous survey of 20 law professors from the Faculty of Law and Political Sciences (FCJP). Central University of Venezuela (UCV). Caracas, 2018.

Medical malpractice can be caused by basic deficiencies in performing medical acts in public health care centers dependent on the State. Table 8 collects the opinions of 20 (100%) active professors of the FCJP of the UCV. Thus, working in unhealthy environmental conditions, with absence or failures of imaging resources, laboratory, hemotherapy, oxygen therapy, auxiliary power plants to supply frequent electrical failures, without intensive care units, food for patients or a milk bank for newborns who require it, with suspension of surgical procedures due to lack of specialized personnel or essential supplies was the response of 9 (45%); Receiving hierarchical pressure that forces the physician to make unethical decisions, such as discharging patients without clinical criteria, prohibiting the referral of compromised patients to better-equipped public centers, receiving despotic, inconsiderate, and inhuman treatment from higher authorities, working in unsafe conditions, without health insurance, without technical-legal advice 8 (40%); placing non-medical personnel or non-meritocratic staff in hospital management positions for political convenience; professional demotivation due to low remuneration cancelled untimely 3 (15%)

11.3.-Interviews

As part of our research plan, we planned to interview professors at the UCV, who contributed their experience and knowledge to this work. As a corollary to the information provided by the professors, we found that in the judicial sphere, medical malpractice is classified as negligent, unintentional conduct on the part of a physician. Any specialty can engage in this practice. However, they believe that the concept of malpractice is unclear in jurisprudence. Sometimes, when a judge faces a case of medical malpractice, he or she does not know how to act because he or she lacks the ability to understand how the human body works. It is difficult for him or her to determine whether it was truly negligence, imprudence, or the individual's own physiology or the progression of the disease that led to a complication or death. It was noted that forensic medicine has not been taught at the Law School of the Central University of Venezuela since 1977, which may explain lawyers' lack of knowledge of this subject.

It is very important that in cases of medical malpractice, medical advice is sought so that the case can be guided on a scientific basis and not by cultural knowledge, and thus obtain a fair verdict. Every doctor should keep the Hippocratic Oath in mind in their daily work. Doctors must prioritize the patient's health over monetary matters; money should always take a back seat. It is very important not to act hastily, to put into practice the knowledge learned, to know that errors can occur in any practice, and to not work under pressure. All specialties seem to be involved; however, the following were mentioned: general surgery, cosmetic surgery, and anesthesiology. Under the current circumstances the country is experiencing, the environment is a factor that

It largely influences the occurrence of medical accidents: For example, if the power goes out in a hospital and the auxiliary plant is not working, there would be no way for the doctor to resolve the situation if he were in the operating room successfully performing a surgical procedure.

There are no statistical figures on medical malpractice, and both negligence and recklessness play a fundamental role in its occurrence. Medical practice is considered dehumanized, yet this situation seems to be observed in all professions. Currently, the aim is to exploit the weakest, coupled with a lack of altruism and human solidarity, and there are many limitations that lead people to act out of necessity. Irregular situations or lack of supplies have been normalized, considered a luxury, and this has led to a moral, social, and cultural collapse.

One of the most important aspects of medical care is the thorough assessment and treatment of the patient, providing a complete and comprehensive explanation of the condition and addressing any concerns appropriately, all of which fosters trust.

What is considered a medical error has been influenced by the variability of contexts and purposes, depending on the perspective of whoever wants to define it, such as research, quality control, ethics, social security, the most fundamental ones focusing on terms of current legislation, legal actions, and regulatory regulations.

There are conditions that prevent a lawsuit for malpractice, including: a lack of confidence in the justice system, coupled with the psychological state of those affected, who are unable to file a complaint. A lack of knowledge of both judges and prosecutors on the subject has also been noted.

Scientific disparity, a misguided sense of "solidarity" on the part of physicians toward other colleagues, a shortage of resources and supplies in both public and private health centers due to the country's economic crisis; and a high proliferation of medical graduates without sufficient and proper academic training. It would be important to emphasize the training of justice officials, since one of the greatest difficulties lies in the preparation and training of the judge to judge the specific case.

Conclusions

Starting from the timeline between the years 2015-2018 in which we carried out our documentary research, we additionally examined complaints of malpractice with definitively final sentences and carried out anonymous surveys. Having to go back to previous periods due to the lack of complaints during our chosen period, we have been able to conclude that:

Medical malpractice is not only a legal issue, but also involves factors such as professional ethics, dehumanization, commercialism, union solidarity, shortcomings in university bioethics teaching, failures in health services, impunity, social skepticism about punishment, and the anomie of the assurance of non-imputability.

In our research, we found that the impunity surrounding medical malpractice is the result of a combination of interrelated factors. First, the prevailing lawlessness in our society, where the law is not enforced and crimes go unpunished; second, the dehumanization of medical practice, where the patient is viewed as an object rather than a human being; and third, medical commercialism, where health care becomes a business. Added to the above is the element of union solidarity that prevails in the medical profession, a form of brotherhood derived from the codes, oaths, and ethical principles of this profession, which could be beneficial or detrimental depending on how you view it.

On the one hand, solidarity could be seen as positive when medical efforts produce a better quality of patient care, since collaboration and communication between members of the medical team increase the effectiveness of treatment, as well as accountability,

motivation and commitment of each physician; the disadvantage is that union solidarity could become an obstacle to identifying and remedying crimes.

The belief that ethics is learned in the family and not at university has been one of the excuses for not giving this discipline the true importance it deserves at the university level. Ethics is related to law in general and especially to human rights. The first challenge to recover the humanization of the doctor-patient relationship is to adequately educate medical students in bioethics in times of crisis, where there is a transition from a solid, stable, repetitive modernity to a flexible, fickle one, where social structures no longer endure over time and are often not useful as reference models.

It has been argued that certain skills are necessary to cultivate humanism in today's world, and it has been proposed that the first skill in higher education should be a critical self-examination of oneself and one's own cultural, moral, and educational traditions. In bioethics teaching, the student has assumed a passive role, merely listening and absorbing, and subsequently translating the information into an exam. A Socratic model is proposed, which questions memorization and obedience, recommending student participation in the teaching process to develop a critical individual, since learning can serve as a means to achieve social transformation. A problematizing bioethics education model is proposed, to question, reflect, and challenge each medical topic during class time. The moral education of physicians should not be abandoned to a hidden curriculum.

The Hippocratic code requires keeping silent the information revealed by the patient, however, over time it has been distorted to

Protecting physicians as a sanctuary of immunity in cases of error and negligence. This presence of implicit codes induces professional practices outside of bioethics and is linked to medical malpractice. Unfortunately, bioethics, in its non-binding deliberative structure, is insufficient to point to jurisprudential and doctrinal precedents for designing a binding regulatory framework, especially in the field of biomedicine. One of the reasons argued is that the principles of biomedical ethics have been defined as principles of common morality, and the understanding and use of these principles differs among those who apply them.

On the other hand, medicine has undergone changes that have disrupted its practice, some related to the health system, others to the economy, medical judgment, imperfect socialization, the physician's relationship with society, and scientific advances.

Medical dehumanization begins at the training level. From the moment they enter the classroom, young students encounter academic demands that entail radical changes in their behavioral patterns and lifestyle. This becomes even more acute when they begin clinical practice, where they must fulfill care commitments, study commitments, and deepen their knowledge of topics. This is where burnout syndrome can occur and is considered a predisposing factor to dehumanization.

This syndrome has alarming growth rates among students, residents, and physicians, and the work environment is also important. It is more common in dehumanized environments, where profitability prevails with an unfair and bureaucratic health system. These conditions are more pronounced in underdeveloped countries due to the lack and deficiency of material and human resources.

Burnout syndrome in physicians can be considered a form of ethical violence, as it affects both the individual and collective level, causing medical errors, lack of empathy and a decrease in the quality of life.

In general, medical care, patients become mere numbers or cases, thus losing their individuality and dignity. Furthermore, it can generate a forced collective morale within the medical field. Doctors may feel pressured to continue working despite being physically and emotionally exhausted. This creates an environment where productivity is prioritized over the well-being of both the doctor and the patient.

Regarding the factors related to the provision, supervision, and control of health services by the State, these can include a myriad of situations that could lead to medical malpractice, such as an abnormal delay in diagnosis or persistent errors, poor organization of care, equipment malfunction, failure to transmit data to the medical record, failure to monitor or follow up the patient, lack of medical resources, and clumsy management, among others. It is imperative to carry out medical activity in an environment with adequate supplies and human and technological resources to arrive at accurate diagnoses.

Regarding strategies commonly used to expose malpractice crimes and achieve greater accountability in the medical field,Media trials or media persecution could hinder justice, which must be impartial and based on concrete facts and evidence. Therefore, media exposure should not replace or hinder the proper and fair judicial process, as it can generate prejudice and affect the objectivity of the process, sowing confusion, despair, and distrust throughout the health sector.

In an effort to find other ways to resolve conflicts, the use of alternative instruments could lead to a significant reduction in both bureaucratic, judicial and management costs, as well as the amount of the

compensation that is usually less than what could hypothetically be obtained in court.

Mediation, out-of-court settlement and arbitration are three options for resolving disputes related to medical malpractice that will not require a trial and that have been used in healthcare-advanced countries such asSweden, New Zealand, Denmark, Finland, Norway, and the United States, where a no-fault liability system has been implemented under different formulas and variations.

From a legal perspective, some authors have suggested that tougher sanctions or penalties for those who commit health-related offenses would reduce the number of these crimes. However, most of the works reviewed in our research warn that the creation of coercive laws against medical malpractice crimes would only lead to higher medical costs, the need for medical malpractice insurance policies, and defensive medicine.

Our research considered ethical, professional, legal, and social aspects, revealing that surveys and interviews with physicians, university professors, and victims of malpractice found a growing disaffection with excellent medical practice, characterized by fear of being victims of retaliation or dismissal, as well as behaviors that lead to neglect of the ethical and humane aspects of the profession. Nearly 100% of respondents indicated the existence of government responsibility in situations that lead to errors that can generate medical malpractice, due to the lack of basic supplies necessary to provide optimal health care.

In relation to Venezuela, there is a panorama of uncertainty regarding the current situation of demands, which contributes to the black figure of the phenomenon, mediated by under-registration, secrecy or denial of

Provide information when requesting the number of complaints filed. Inaccuracies and errors in records are found, which, combined with other concomitant factors, make it impossible to apply sanctions, leading to impunity influenced by personal, legal, political, or social factors.

Recommendations

We consider medical malpractice to be a multifactorial problem, which becomes more prevalent when several factors converge. As a problem that involves several aspects in its proper approach, and based on our research, we propose the following recommendations to mitigate or reduce its occurrence:

a) **In the human and educational aspect:** Derived from the bioethical study of this problem in our thesis, we consider that the physician should always have as a guide the ethical principles such as primum non nocere or first do no harm, there is a weakness in the ethical and humanistic training in the physician, which seems to be linked to the hidden curriculum described in the first chapters of our research, therefore, the study plans should be reviewed by university authorities, in order to include discussions about errors and medical malpractice in each subject, resuming the anatomical-clinical meetings where the postmortem findings of patients are discussed contrasted with the diagnoses of disease, since there is a considerable discrepancy between medical and forensic diagnoses that have remained at a percentage of approximately 25% despite the advances in science and technology; an issue that we address when developing the topic of the value of autopsies in our work. It is necessary to open new spaces for training and research in the area of bioethics, in order to reflect on the impact of science and technology based on our historical and cultural visions; in such a way that we can transcend from the practical vision (bioethics committees) and normative (bioethics codes) to a contextualized epistemological dimension. Associated with this, there seems to be an overload of work among physicians, which in some cases could result in a burnout syndrome or professional exhaustion, this situation added to the fame and the

The commercialization of the medical profession, precarious salaries, and the high cost of living would contribute to the relativization of ethics and humanism, which would be relegated to a secondary level according to the data obtained from our surveys. We have observed that many errors and cases of malpractice are due to the excessive self-confidence of the physician, so we believe that the physician should recognize those areas in which he or she is not sufficiently qualified to resolve a health problem, having to refer the patient to another, much more advanced colleague or request their collaboration. Our assertion is based on the development of the topic of medical narcissism in our research, in addition to the codes and laws that consider this duty. We must not forget that the psychological aspect of each human being will always be involved, a point addressed in our section on the Lucifer effect, where we refer to the way doctors act, considering good and bad doctors.

b) **Social factor:**The existence of a crisis of values condemns compliance with ethical codes, which have been relaxed and relegated to a secondary role. Rebuilding the social fabric would encompass our cultural, economic, and political identity.

c) **Union factor:**As we have observed throughout our research, the medical profession, since ancient times, has been seen as a brotherhood, and this has been reflected in the Corpus Hipocratium, where Hippocrates of Cos, the father of medicine, would consider his colleagues as brothers and sisters, derived from this factor, and over time, it has been distorted, not only to keep the secrets of the patient, but to hide from the patient situations that generated medical malpractice, while avoiding reporting any unethical behavior of a medical colleague, so it would be worth mentioning the possibility of the existence of automatic solidarity in the medical profession, and although theunion solidarity of the

Doctors' ethics could be a powerful tool to improve the quality of patient care, but it could also lead to cover-ups and medical malpractice. Therefore, we believe it is important to reactivate Bioethics Committees in healthcare institutions, in order to foster a culture of transparency, honesty, integrity, and accountability to ensure that the harm caused is identified and repaired in a timely manner.

d) **Government factor**: It is impossible to carry out adequate medical practice when the most essential elements (e.g., water, electricity, availability of a blood bank, trained personnel, medications, among others) are absent. Within the scope of medical practice, there will be a greater possibility of arriving at an erroneous diagnosis if the minimum tools that should be present in every healthcare institution are not available; therefore, decent conditions for the development of medical practice must be demanded, as well as the provision of supplies and trained personnel, avoiding duplications that could cause medical errors. Although in recent years we have seen that telemedicine has been advancing, permeating various areas of medical practice, it should go hand in hand with the in-person nature of medical practice.

e) **Legal factor**: It is necessary to highlight the existence of impunity in the crimes of medical malpractice, a situation that occurs when weak, slow and inefficient judicial systems coexist, the existence of corruption and a lack of qualified personnel and financial resources, associated with the lack of information of patients about their rights and the legal recourse available to them, therefore, improving the existing weaknesses in this area and studying the possibility of implementing mechanisms for extrajudicial resolution of conflicts due to medical malpractice could provide fair solutions.

In the words of Cesare Beccaria: “L**The certainty of a punishment, even if moderate, will always make a greater impression than the fear of a more terrible one, but combined with the hope of impunity; because evils, even if small, when they are certain always frighten the spirits of men; and hope, a heavenly gift, which usually occurs in everything, always separates the idea from the greater ones, especially when impunity, so in accord with avarice and weakness, increases its strength.**”

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ANNEXES

INSTRUMENT TO USE: SURVEY.

This survey, authored by the authors, is an opinion poll on "medical malpractice" committed by healthcare personnel working in Caracas' main hospitals. Its purpose is strictly academic and its confidentiality is absolute. There is no way to determine the origin of the different opinions, in accordance with the Statistical Secrecy Law.

Please read carefully and answer honestly. You may use the back of the pages to expand your answers. Mark your positive response with an "x." You may use the back of the sheet.
Thank you very much for your collaboration!

PART A:*Questions for the medical profession.*

1.- Specialty: yes_____No____Which:_____ 2.- Years of practice:_____

2.- Do you consider that the responsibility in the health area is: Only the doctor's:_____It depends on the hospital conditions: availability of supplies: Environmental conditions:_____sufficient medical staffing: _____Paramedic staffing:_____of the patient:_____from the patient's relatives: _____fortuitous event or force majeure:_____of Directors and authorities of health centers: _____From the nurses:____ All: Deficiency in medical training:_____ Others): _____None:___

3.- In your opinion, under what circumstances have you observed > medical malpractice: due to poor surgical technique:_____due to the foreign body being left inside the abdomen:_____perforation of the airways or digestive tract:_____ perforation when catheterizing a vessel:_____In anesthesiology: _____Due to lack of oxygen:___Due to the absence of resuscitation mechanisms:____ _____forgetting to administer medication:_____ mistake in choosing the right medication:_____expired sutures:_____poor sterilization of surgical material: _____contaminated prostheses:____amputation of vital organs (ureter, tubes, ovaries, breasts, eyes, etc.):
_____injuries to the newborn during cesarean section or delivery in skin, fractures or others:____

4.- In your health center there are shortages of supplies in: medications:_____laboratory:_____Imaging: _____Radiodiagnosis:_____Specialists:_____ paramedics:_____ environmental safety: _____personal safety:_____professional improvement teams:___alarm equipment against foreign attacks or risks:_____accident prevention:_____ Disasters:_____ Security : _____Nursing:_____

5.- You observe that physical exhaustion as a triggering factor in excessive working hours occurs in: medical shifts of more than 24 hours:_____24-hour shifts where the doctor doubles up during the day _____night shifts alone and with excess patients under their responsibility: _____shifts of more than 24 hours every 5 days when sick or convalescing:_____ _____

6. In your professional opinion, could fatigue during the workday contribute to medical malpractice? Yes: No: ; When it is doubled during on-call shifts? Yes: No: ; When working at night with an excess of critical patients and without another physician on the team: Yes: No:

7.- Do you consider that most cases of malpractice are caused by: abstention or non-performance of the indicated conduct; lack of prudence; lack of skill in the technique or professionalism; ignoring rules, protocols or hierarchy; Lack of academic training;_____In his professional experience, he believes that they could be avoided in more than 50% or more than 90% of cases.

8.- Have you witnessed preventable medical errors? Yes: No In the surgical area: medical: dental: Intensive care: hospital emergency: Delivery room: laboratory: office: other:____

9.- Do you consider that your hospital has all these resources: medications: yes_____No___; imaging: yes_

No___; specialized laboratory: yes:_____No:_____; interconsultations with other specialties: if:_____No:

_____; logistical support in extreme situations: if:_____No:_____; safety of your physical, moral, and psychological integrity against external aggression when performing a medical procedure: if:___No:_____by the institution
:_____Union:_____scientific societies:_____

10.- In your professional experience, has an undesirable event occurred during the administration of a medication? Yes: No: ; Error in a technique or procedure? Yes: No: ; Unknown situation or event? Yes: No: ; Other:_____ _____; Has a patient's exam ever been lost?: Yes: No: ; Has a patient's exam been confused with another patient's?: Yes: No: ; Has a patient's medical record been lost?: Yes: No: What has been the conduct and the information supplied to the sick person?_____

11.- In your opinion, is there a higher incidence of malpractice in public health centers? Yes:_____No:___; in private centers?: yes:____No:_____; Do you think this is important?: Yes:___No:_____because?:_____

12. Are you assertive, considerate, and patient when delivering serious information to patients/family members? Yes: No: Do you handle your own stress and emotional tension well during these times? Yes: No: If aggression from the patient/family occurs, do you think you would know how to handle it appropriately? Yes: No: Please give your opinion on how you would handle it._____

13.- What other factors, besides the treating physician, would in your opinion be responsible for the success or failure of medical treatment or surgical intervention? Mention 3

13.1.-

13.2.-

13.3.-

14.- Do you believe that you are aware of the notion of a doctor's criminal liability when treating a patient? 13.1.- Yes:_____13.2.- no:_____13.3.- Why?:_____

15.- Do you think medicine is currently dehumanized? Yes: No: Which of the following factors do you think are involved: commercialism:_____Burnout Syndrome (professional burnout):_____Lack of ethics:_____Poor professional training: Others: (mention):

16.- Have you felt any type of hierarchical pressure in your professional practice from the authorities of your hospital? Yes: No: In what sense?: forced to admit excess patients; prohibiting the referral of patients to other centers; working overtime or redoubling; working in ergonomically poor conditions; unsanitary conditions; Forced to discharge patients who do not meet discharge criteria to clear beds/spaces; working with precarious supplies:

17.-Have you been victim of demands and/or complaints before hierarchical? Yes: no: Which: _____Cause:_____

18.- Have you made a decision in your professional practice that borders on or contradicts medical ethics? Yes: _____No:_____Which:
_____Because?:_____

19. Have you ever observed unethical behavior in any of your colleagues? If so:_____No: _____Which:_____

20.- Final comments and suggestions. (You may use the entire page on the back.)

PART B: *Questions for the legal profession.*

Self-authored survey, an opinion poll on medical malpractice committed by health personnel and aims to learn about personal experiences that legal professionals in the city of

Caracas. Its purposes are strictly academic, and its reliability is absolute. There is no way to determine who owns the different opinions, in accordance with the Statistical Secrecy Law..

Please read carefully and answer honestly. You may use the back of the pages to expand your answers. Mark your positive response with an "x." You may use the back of the sheet.

Thank you very much for your collaboration!

1.- Age:_____Years in professional practice:_____Specialty:_____

2.- Have you been the victim of any type of medical malpractice? Yes: No: Type: Did you file a lawsuit? Yes: No: Why:_____Results of the claim:

3. Do you find it particularly difficult to obtain a favorable judgment in the case of a healthcare professional convicted of medical malpractice? If yes, no, why?_____What do you think are the most decisive factors involved? Inherent to the judge: Inherent to the process: Difficulty in the evidentiary act: _____corruption:_____other (explain):_____

4.-What type of tools would you recommend to reduce the incidence of medical malpractice?

5.- Which is the specialty medical according to his criterion where ha observed elderly malpractice?_____Because?_____ _____

6. Do you believe that the physician is aware of the notion of criminal liability when performing the medical act? Yes: _____No:_____

7.- Do you consider that the responsibility in the health area is: Only the doctor's:_____It depends on the hospital's administrative conditions: provision of supplies: Environmental conditions:_provision ofsufficient medical personnel:__ _____Paramedic staffing:_____of the patient:_____ from the patient's relatives:_____fortuitous event or force majeure:_____

8.- Do you consider that the lack of equipment influences the commission of medical malpractice? Yes: No: Which ones? medications:_____ laboratory:_____ Imaging:_____ Radiodiagnosis: _____Specialists:_____ paramedics:_____ poor vocational training:____ Ethics:_____Others:_____

9.- Do you consider the physical exhaustion of healthcare personnel to be a triggering factor for malpractice? Yes: _____No:_____

10- Do you consider that most cases of malpractice are caused by: negligence:_____imprudence: _____inexperience:_____non-compliance with the rules:_____He believes that they could be avoided by more than 50%._____ or in +90%_____

11.- In your opinion, is there a higher incidence of malpractice in public health centers? Yes:_____No:___; in private centers?: yes:____No:_____; Do you think this is important?: Yes:__No:_____because?:_____

12.- In your experience, do you find doctors assertive and considerate when giving serious information? Yes: _____No:_____

13.- Do you think medicine is currently dehumanized? Yes:_____ No:___ Which of the following factors do you think are involved: mercantilism:_____Professional exploitation:_____Lack of ethics: _____Others: (mention)

14.- Have you ever observed unethical medical conduct on the part of a medical professional?: Yes: _____No:_____Which:_____

15.- In the medical interview, what is the element that you value most: respect:_____ empathy: _____confidentiality:____trust:_____satisfactory explanation:_____

16.- Final comments and suggestions. (You may use the entire page on the back.) Thank you very much for your collaboration!

Part C: ***Questions directed to the patient and/or their relatives*.**

This survey, authored by the authors, is intended to gather public opinion on medical malpractice committed by both the medical staff and the healthcare team providing services at this Caracas hospital. Its purpose is strictly academic and its reliability is absolute. There is no way to determine whose opinion belongs to it, as it is protected by the strictures of the Statistical Confidentiality Law..

Please read carefully and answer honestly. You may use the back of the pages to expand your answers. Mark your positive response with an "x." You may use the back of the sheet.

Thank you very much for your collaboration!

Age: Sex: M: F: Was the patient: yes: no: If family, indicate relationship with the patient: _____ Have you been the victim of any type of medical malpractice? Yes: No: Could you briefly explain what happened?

In your opinion, why did the medical malpractice occur?

In which medical area or discipline did it occur?

Do you think the responsibility was solely the doctor's?

In your opinion, could the current shortage situation predispose to medical malpractice?_____Do you think that the overwork of health professionals would contribute to the consolidation of malpractice?

You believe that most cases of malpractice are due to: lack of prudence; lack of skill or inexperience; failure to perform due conduct:_____failure to comply with protocols or regulations:

Do you believe that the medical professional violated his or her ethical principles in his or her actions? Yes: _____No: _____Which is it?

Did the doctor demonstrate empathy and assertiveness?: Yes: No: Did he explain the technique, procedure, or treatment to be used? Yes: No: Was he sincere when delivering the bad news of the event that occurred?: Yes: No: Do you know what your rights are as a patient according to the codes of ethics? Yes: No:_____

Did you sue? Yes:_____No:_____Because?:_____

In your opinion, do you think medical practice has become dehumanized? Yes:__No:___ What do you think could be the cause?

Additional comments:

Thank you for your contribution!